

Alconbury & Brampton Surgeries

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.

Ratings

Overall rating for this service

Good



Are services safe?

Requires improvement



Are services effective?

Good



Are services caring?

Good



Are services responsive to people's needs?

Good



Are services well-led?

Good



Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Alconbury & Brampton Surgeries on 24 November 2015. 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.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The dispensary was well run and people received their medication in a safe and timely way.

- There were high levels of patient satisfaction with the service demonstrated by the National GP Survey, the 46 comments cards we received and from the patients we spoke with on the day of our inspection
- Patients with caring responsibilities were proactively identified and supported by practice staff.
- Information about services and how to complain was available and easy to understand, and complaints were dealt with in a timely way.
- Patients said they found it easy to make an appointment with a named GP and that 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.

Summary of findings

We saw several areas of outstanding practice including:

- The practice had a very active and involved patient participation group which raised money for equipment and ran a voluntary patient transport service. The practice had facilitated patient education meetings on issues such as carers' needs, smoking cessation and with the diabetic nurse specialist.
- The practice ran an award scheme which recognised good work amongst its staff team.

The areas where the provider should make improvement are:

- The practice should improve the way it manages patients on medicines that require regular blood testing and monitoring.

- The practice should improve the way it implements and reviews action taken in light of MHRA alerts to ensure patient safety.
- The practice should improve the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance).
- The practice should ensure that it records any action it takes in response to the non-attendance of a child at a hospital appointment in the child's notes.

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 requires improvement for providing safe services.

There was an effective system in place for reporting and recording significant events and lessons were shared to make sure action was taken to improve safety in the practice. Safeguarding procedures were good and risks to patients were assessed and well managed. Patients received care in an hygienic and clean environment. However, patients on high risk medicines were not always monitored closely enough to ensure they were receiving regular blood tests in line with national guidance.

Requires improvement



Are services effective?

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met people's needs. Clinical audits were completed and demonstrated quality improvement. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to understand and meet the range and complexity of people's needs.

Good



Are services caring?

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently and strongly positive

Data showed that patients rated the practice higher than others for several aspects of care and we noted several examples of where staff had gone beyond the call of duty to assist patients. Patients reported that they were treated well by staff, and that they were involved in decisions about their care and treatment.

Good



Are services responsive to people's needs?

Patients said they found it easy to make an appointment with a named GP and that 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.

Good



Summary of findings

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff.

Are services well-led?

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

There was a clear leadership structure and staff felt supported by management. There was an overarching governance framework which supported the delivery of the strategy and good quality care. The practice proactively sought feedback from staff and patients, which it acted on and the patient participation group was active.

Good



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 offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in end of life care. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The percentage of patients aged 65 years or over who received a seasonal flu vaccination was higher at 82% than the CCG and national averages.

Home visits and rapid access appointments were available for those with enhanced needs. The practice offered a dispensary delivery service for patients unable to make regular visits to the surgery.

People with long term conditions

GPs worked with relevant health and care professionals to deliver a multidisciplinary care package to patients with the most complex needs. Patients at risk of hospital admission were identified as a priority. Nursing staff were experienced and well trained in chronic disease management, and the practice offered regular reviews of patients' health resulting in lower than average hospital admissions. We saw good examples of joint working with community matrons and nurse specialists.

Good



Families, children and young people

The practice offered a wide range of family planning advice and treatment to all age groups. It also offered young people teenage health checks which included advice on contraception and sexual health, when they attended for booster vaccinations. Chlamydia screening services were available for 16-24 year olds. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies

Good



Working age people (including those recently retired and students)

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. It provided some remote care monitoring including 24 hours blood pressure and cardiac event monitoring to minimise the need for patients to attend hospital for investigations.

Good



People whose circumstances may make them vulnerable

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding

Good



Summary of findings

information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. People with learning disabilities were offered annual health checks.

The practice's patient participation group co-ordinated a volunteer driver scheme enabling vulnerable patients to attend appointments at the practice, and other health care settings.

People experiencing poor mental health (including people with dementia)

Patients with significant mental health problems had annual mental health and medicines reviews, and many had their own care plan in place.

One of the partners was the CCG's dementia lead and the practice had worked proactively to identify patients with dementia to ensure they received adequate support. 97% of people diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. 82% of patients with serious mental health problems had an agreed care plan

Team. The practice has a comprehensive counselling patient information leaflet and referred patients to the local IAPT (Improving access to psychological therapies) team.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on 2 July 2015. The results showed the practice was performing well above local and national averages. 254 survey forms were distributed and 136 were returned.

- 92 % found it easy to get through to this surgery by phone compared to a CCG average of 76 % and a national average of 73%.
- 96 % found the receptionists at this surgery helpful (CCG average 88%, national average 87 %).
- 96 % were able to get an appointment to see or speak to someone the last time they tried (CCG average 88%, national average 85%).
- 99 % said the last appointment they got was convenient (CCG average 93%, national average 92%).
- 92 % described their experience of making an appointment as good (CCG average 77%, national average 73%).

- 84 % usually waited 15 minutes or less after their appointment time to be seen (CCG average 65 %, national average 65 %).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our visit. We received 46 comment cards which were all hugely positive about the standard of care received and the quality of the practice's staff.

We spoke with the managers of two residential care homes that the practice supported. Both spoke highly of the practice, stating that they received an efficient and responsive service. One manager reported that the GPs showed incredible patience with their residents, who often changed their mind last minute as to whether or not they wanted to see a doctor. The other manager appreciated the fact that the same GP visited the home allowing for staff, residents and relatives to build up good relations with them.

Areas for improvement

Action the service **SHOULD** take to improve

- The practice should improve the way it manages patients on medicines that require regular blood testing and monitoring.
- The practice should improve the way it implements and reviews action taken in light of MHRA alerts to ensure patient safety.
- The practice should improve the security of prescription forms throughout the practice in line with national guidance (NHS Protect Security of Prescription Forms Guidance).
- The practice should ensure that it records any action it takes in response to the non-attendance of a child at a hospital appointment in the child's notes.

Outstanding practice

- Learning from significant events was taken seriously by the practice and each of the practice's sub teams (secretaries, nurses, receptionist) shared an event that had affected their team at the regular practice wide meetings.
- The practice had a very active and involved patient participation group which raised money for equipment and ran a voluntary patient transport service. The practice had facilitated patient education meetings on issues such as carers' needs, smoking cessation and with the diabetic nurse specialist.
- The practice ran an award scheme which recognised good work amongst its staff team.

Alconbury & Brampton Surgeries

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Alconbury & Brampton Surgeries

Alconbury and Brampton Surgeries are well-established GP surgeries that have operated in the area for many years. They serve approximately 9,300 registered patients and have a general medical services contract with NHS Cambridgeshire and Peterborough CCG. The practice is based on two sites, one in Alconbury and the other close by in Brampton. It is located in an affluent area of Cambridgeshire and has very low rates of deprivation.

According to information taken from Public Health England, the patient population has a higher than average number of patients aged 40-85 years, and a lower than average number of patients 15-39 years compared to the practice average across England.

The clinical team consist of a partnership of four GPs, three salaried GPs, three practice nurses, and three health care assistants. The administrative team is led by the practice manager and consists of a management assistant, three medical secretaries, nine receptionists and five dispensers.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 24 November 2015. During our visit we visited both sites and spoke with a range of staff including GPs, nurses and administrative staff. We also reviewed comment cards where patients and members of the public shared their views and experiences of the service, and spoke with a small number of patients.

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?

Detailed findings

- Is it well-led?

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)

- 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. Significant events and complaints were discussed routinely at the fortnightly GPs' meetings, evidence of which we viewed. In addition to this, staff told us they were asked to bring examples of significant events to the twice yearly staff forum meeting for discussion. Minutes of the staff forum held on 15 July showed that each of the practice's sub teams (secretaries, nurses, and receptionists) shared a significant event that had affected their particular team.

The practice carried out a thorough analysis of the significant events, and we viewed records of over 40 incidents that had occurred since January 2015. The action taken in their light, how the learning was shared and the date they had been reviewed were clearly recorded.

There was a system in place to cascade information from safety alerts, including those in relation to medicines. One of the GPs told us that searches were undertaken in response to the safety alerts and changes were made in the records of prescription amendments, or notes made to detail why no prescription changes were required. Whilst the practice did have procedures in place to deal with MHRA alerts, on occasion they placed too much weight on the clinical opinion of local specialists with regard to risks, as opposed to implementing nationally accepted safety guidance alerts. We checked what action the practice had taken in response to three alerts concerning the medicines simvastatin, domperidone and clopidogrel and found:

- Four patients who had been prescribed simvastatin in combination with other medicines that increased risk to patient safety, despite one of these patients having at least three medication reviews whilst on this combination.
- 13 patients had been prescribed more than 30 domperidone in the past year, and all had an alert on their records. However, it was not clear that this had been responded to in all cases.

- 27 patients who had been prescribed clopidogrel in combination with omeprazole/esomeprazole. This combination could reduce the efficacy of clopidogrel and could lead patients to a possible risk of clotting in cardiac stents or increased cardiovascular risk.

Safeguarding

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 were lead members of staff for safeguarding patients and staff we spoke with demonstrated they understood their responsibilities: all had received training relevant to their role.

Patients with any safeguarding concerns were highlighted on the practice's computer system so that clinicians were aware of any concerns. We viewed minutes of meeting on 3 September 2015, where children with safeguarding concerns had been discussed with the health visitor. However, following a recent audit of its safeguarding procedures, a plan was in place to arrange increased meetings with both health visitors and school nurses to discuss children with safeguarding concerns.

We viewed GP meeting minutes of 7 May 2015 where the partners had reviewed the local medical committee's guidance on child protection case conference reports and implemented a number of its recommendations as a result.

We looked at the records for 14 patients under the age of 16 years who, in the previous 12 months, had not attended their hospital appointment. We found that although there was a record in their clinical notes that they had not attended the appointment, often there was no further record of how the practice had followed this up.

A notice in the waiting room and above treatment couches advised patients that chaperones were available if required. Chaperoning was provided by the practice's nurses or health care assistants who were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they might have contact with children or adults who may be vulnerable).

Cleanliness and infection control

Are services safe?

There was an infection control protocol in place and staff had received up to date training. One of the nurses took the lead for infection control within the practice.

We observed that all areas of the practice's branch at Alconbury were visibly clean and hygienic, including the waiting area, corridors and consultation rooms. The patient toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked two consultation rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and sealed work surfaces so they could be cleaned easily. There were prompter posters above each sink reminding staff of the correct way to wash their hands. We saw that sharps' boxes had been assembled correctly and were not overfull. Bins were foot operated to maintain hand hygiene.

A weekly list of cleaning tasks was in place and the practice conducted its own infection control audits. These were comprehensive and covered, amongst other things, the cleanliness of the environment, waste management and bodily fluid spillage.

The practice had completed a risk assessment for legionella (a bacterium which can contaminate water systems in buildings) and we saw records that confirmed it was carrying out regular checks to reduce the risk of infection to staff and patients. The manager had recently undertaken additional training in Legionella management.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential fridge failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Staff were aware prescriptions should be signed before being dispensed. In some circumstances prescriptions were not signed before they were dispensed and given to the patient but staff were able to demonstrate that a process was followed to minimise risk.

Both blank prescription forms for use in printers and those for hand written prescriptions were logged and tracked through the practice but were not stored securely in all areas in line with national guidance.

The nurses used Patient Group Directions to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistants administered vaccines and other medicines using Patient Specific Directions that had been produced by the prescriber. We saw evidence that nurses and the health care assistants had received appropriate training to administer vaccinations.

The practice held stocks of controlled drugs (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 practice staff and included stock held in the doctors' bags. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. However, there was no record made of patient returned controlled drugs at the time they were received. We discussed this with the dispensary supervisor who told us they would review the procedure and make the necessary changes.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). We saw that dispensary staff had identified concerns around controlled drugs and that changes had been made to prescribing patterns to support people who had difficulty in managing their medicines safely.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. It had recently implemented a protocol for adding regular medications prescribed and administered by the hospital to patients' records. The practice was signed up to the Dispensing Services Quality

Are services safe?

Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

We saw a positive culture in the dispensary for reporting and learning from medicines incidents and errors. We saw minutes of meetings which showed that incidents were reviewed and that appropriate actions were taken to minimise the chance of similar errors occurring again. We saw that stickers had been introduced to identify prescriptions for high risk medicines such as warfarin and methotrexate so that staff could make sure people had the right information to take the medicine safely.

Dispensary staff offered a limited delivery service and the practice manager told us that they used this as an opportunity to keep in touch with people who couldn't attend the surgery. We saw a letter from a patient's family which showed how much this was appreciated.

We reviewed how the practice managed patients who took medicines that required specific blood monitoring. We found that the monitoring for patients on disease modifying anti-rheumatic drugs and lithium were in line with recommendations. However we found 12 of 389 patients who were prescribed levothyroxine had not received a thyroid function test in the previous 18 months. We also found 39 of 985 patients on ARB and ACE inhibitors had no coded entry for creatinine checks in the last 18 months. Although some of these patients might have had their results monitored in hospital, we found no record of hospital renal screening having been completed on some of the records.

In addition to this we identified an occasion when one of the practice's health care assistants had undertaken a medication review for a patient and had also entered quite a lengthy review date in excess of 12 months. Although one of the GPs assured us this was not normal practice we were not provided with an explanation of how this had occurred.

Staffing and recruitment

We reviewed four staff personnel files and found that appropriate recruitment checks had been undertaken prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. All new staff underwent an induction period to become familiar with their role. We

spoke with one member of recently recruited staff who told us their induction been thorough, and that their performance had been appraised by the lead GP for administrative staff after three months.

The practice manager told us about the arrangements for planning and monitoring the number of staff and there was a minimum staffing policy in place. Staff told us there were enough of them to maintain the smooth running of the practice and that there were always enough of them on duty to keep patients safe.

Monitoring risks to patients

There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available and the practice had up to date fire risk assessments and carried out regular fire drills. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.

All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. We saw evidence of the calibration and service of relevant equipment such as spirometers, Doppler's and nebulisers.

Arrangements to deal with emergencies and major incidents

Records showed that all staff had received training in basic life support. Emergency equipment including oxygen and automated external defibrillators (used in cardiac emergencies) were available in the practice. Staff all knew the location of this equipment and records confirmed that it was checked regularly by nursing staff. We saw that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff and all staff knew of their location. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice such as the loss of premises or utilities, or the death of a GP.

Are services safe?

Reception staff had specific evacuation packs containing essential information that could be grabbed in the event of a serious emergency. In addition to this, the practice had recently acquired two laptops, giving them secure remote access to their clinical system in the event of an emergency.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed patients' needs and delivered care in line 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 and there was a practice protocol in place to ensure that NICE guidelines were disseminated to clinicians. All clinicians we spoke with were good at recognising and knowing where to look for new guidelines both nationally from NICE and more locally. They were aware of email systems for NICE updates and also on-line clinical knowledge systems. All of the GPs used 'GP Notebook' (an online encyclopaedia of medicine that provides a trusted immediate reference resource for clinicians in the UK and) as a source of guidance for protocols and evidence based medicine. The GPs also used a specialist computer programme to support medicine prescribing decisions

Minutes of both GP and nurses meetings we viewed showed that latest guidelines and research were discussed to ensure best practice was followed.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Each of the practice's partners led on delegated areas within QOF. The most recent published results were 98.8 % of the total number of points available, with a 5% exception reporting. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014-2015 showed;

- Performance for diabetes related indicators was 98%; 8.2 percentage points above the CCG average and 8.5 percentage points above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was 100%; 1.9 percentage points above the CCG average and 2.2 percentage points above the national average

- Performance for mental health related indicators was 100%; 7.6 percentage points above the CCG average and 7.2percentage points above the national average
- The dementia diagnosis rate was 100%; 5 percentage points above the CCG average and 5.5 percentage points above the national average

The practice had undertaken a range of clinical audits, particularly in response to local formulary initiatives and particularly because it had a higher than CCG average for the prescribing of quinolones, cephalosporins and co-amoxiclav. The full cycle repeat audits we viewed showed some increased adherence to current local guidelines which was noteworthy. The practice also undertook annual audits as part of its accreditation to the Dispensing Services Quality Scheme, the most recent relating to the availability of prescribed medicines to meet patients' needs. Non-clinical audits were also completed to drive improvements in patient care. For example, the practice had conducted a specific carers' audit to ensure patients' next of kin data was up to date and the required consents for information sharing were documented. Another was undertaken in to assess its performance in relation to health checks for people with learning disabilities. However nursing staff told us they were not actively involved in auditing and had not completed any audits in the areas of service they were involved in. The practice manager reported that audit was an area she felt the practice could improve on.

The practice was an accredited research and practice and participated in applicable local audits and research. For example, it was participating in the Very Brief Interventions study (VBI) run by Cambridge University to assess the efficacy and cost effectiveness of brief interventions to increase physical activity among adults attending NHS Health Checks. It had also participated in a study about in the use of the drug theophylline in the treatment of chronic obstructive pulmonary disease.

The practice had identified its patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. Personalised care plans had been developed for these patients to improve the quality and co-ordination of their care.

Are services effective?

(for example, treatment is effective)

Emergency hospital admission rates for the practice were slightly below at 12.88% compared to the national average of 14.4%.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

The practice had a well-established and stable staff group many of whom had worked there for a number of years. Figures provided to us by the practice manager showed that the average length of service amongst the staff team was 9.5 years, with two staff having worked for 27 years.

We found that staff had the skills, knowledge and experience to deliver effective care and treatment. The Practice manager held an AMSPAR (Association of medical Secretaries, Practice Managers, Administrators and Receptionists) Diploma in Primary Care, and was an accredited NLP Business practitioner.

Two of the nurses held Diplomas in Diabetes Care, one in Asthma and another in Spirometry. The nurses told us that the practice supported them to maintain their clinical professional development through training and at attendance at local nurse forum meetings and study days. One nurse reported that requests for training were always considered. One of the GPs told us they regularly attended 'Hot Topics' update courses which they found useful to keep their practice up to date.

All staff had access to, and made use of, e-learning training modules and in-house training. Non clinical staff received training that included safeguarding adults and children, fire procedures, infection control, basic life support, and equalities and diversity. There was protected time once a fortnight for educational meetings and training for both clinical and non-clinical staff. We viewed a comprehensive timetable for these meetings which included sessions on mental capacity, dementia, carers' needs and asthma management.

All staff had received an appraisal within the last 12 months and salaried GPs had an internal appraisal in addition to those required for their revalidation. Staff

told us they found their appraisals useful and one of the practice's dispensers reported that, as a result of her appraisal, a need for a supervisor's course had been identified and agreed.

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. GPs took full responsibility for summarising patient records and for all Read coding.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. We found many examples of joint working with other health and social care professionals such as community matrons, multiple sclerosis specialist nurses and the Huntingdonshire Community Cancer network. For example, staff met with the local learning disability team 15 October 2015 to discuss patients on the practice's learning disability register and ensure it was accurate and up to date. In July 2015, staff met with the multiple sclerosis (MS) nurse to discuss a new MS pathway for patients taking prescribed steroids.

The practice provided GP care to patients living in two local care homes. Representatives from these care home confirmed that the practice worked with them in a supportive and helpful way to maintain their residents' well-being.

Consent to care and treatment

The practice had a consent policy in place providing guidance for staff the different types of consent a patient could give, and how to obtain consent for children. This was also on display in the waiting room making it easily available to patients. Patients we spoke with told us that they were provided with sufficient information during their consultation and that they always had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

The practice had appointed one of its GPs to be the lead for the Mental Capacity Act (MCA) and all the clinical staff we

Are services effective?

(for example, treatment is effective)

spoke with understood the key parts of Mental Capacity Act (MCA) legislation and were able to describe how they implemented it in their work. For example, one GP showed a good understanding of the complex consent and best interest issues involved when their patient had refused to be admitted to a residential care home. One of the nurses showed us a poster on the treatment room wall which clearly outlined the key principles of the MCA. She was aware of the importance of gaining the correct parental consent when giving children their vaccinations. A care home manager stated that the GPs undertook mental capacity assessments for their residents if needed.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence and Fraser Guidelines. (This helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). One of the GPs described to us how she took them into account when deciding to prescribe contraception to young people. Staff training records we reviewed showed that both clinical and non-clinical staff had received recent training in understanding Gillick competence to ensure their understanding of the guidance.

Written patient consent forms were used for minor surgery and contraceptive implants.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice had an informative website which provided information about a wide range of health and care topics and there were leaflets in the waiting rooms, giving patients information on a number of medical conditions.

Patients had access to appropriate health assessments and checks. These included health checks for people aged between 40 and 74 years and figures given to us by the practice showed that a total of 386 completed checks had been undertaken for eligible patients between October 2014 and September 2015. The practice also offered health checks for patients with a learning disability. The practice had 28 people with a learning disability on its register, and all but three had been seen for a check in the 12 months prior to our visit.

All clinical staff had received training in smoking cessation and patients could be referred to a number of local schemes for weight and alcohol management. A member of ALBRAM (the practice's patient participation group) told us that one of the practice's health care assistants had given up their Saturday afternoon to attend the local summer village fete to provide free blood pressure checks to the public.

The practice offered chlamydia screening for young people aged between 16 and 24 years. Uptake for the cervical screening programme was 85%, which was comparable to the national average of 82 %. Childhood immunisation rates for the vaccinations given were slightly above national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 78% to 96 % and five year olds from 78% to 95 %. Flu vaccination rates for the over 65s were 82 %, and at risk groups 61 %. These were also above national averages of 73% and 52% respectively.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spent time in the patient waiting area at the Alconbury branch and observed a number of interactions between the reception staff and people coming into the practice. Overall, the quality of interaction was good, with staff showing empathy and respect for patients, who did not wait long to be seen. Clinicians called through patients into consulting rooms in person, and in a friendly and professional manner.

We found that the reception area at Alconbury was not particularly private and that conversations between reception staff and patients could be overheard easily. However, a poster advised patients that a private room was available needed and the practice had recently introduced a patient queuing system to help maintain privacy. We noted that radio music played in the background to help distract those waiting. Consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.

We received consistently positive feedback about the practice from the 46 patient CQC comment cards that had been completed by patients. Patients said they felt the practice offered an excellent service and that staff were responsive, caring and treated them in a way that they liked. Patients commented that staff listened to them and took their health concerns seriously.

Staff gave us specific examples of when they had gone above and beyond the call of duty. For example, one of the dispensers regularly stayed for a cup of tea and chat with a particularly isolated patient and one of the GPs had delivered some books to a patient they were visiting. A member of the ALBRAM told us that one of the GPs had popped by opportunistically to see a patient as they were concerned about them.

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

- 98% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 95% said the GP gave them enough time (CCG average 87%, national average 87%).
- 98% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%)
- 94% said the last GP they spoke to was good at treating them with care and concern (CCG average 86%, national average 85%).
- 96% said the last nurse they spoke to was good at treating them with care and concern (CCG average 91%, national average 90%).
- 96% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%)

Care planning and involvement in decisions about care and treatment

Patients told us that 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 on the comment cards we received was also positive and aligned with these views.

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:

- 95% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 91% said the last GP they saw was good at involving them in decisions about their care (CCG average 82%, national average 81%)

Patient and carer support to cope emotionally with care and treatment

Notices and leaflets in the patient waiting area told patients how to access a number of support groups and organisations including those for psychological well-being services, bereavement services and family

Are services caring?

counselling. One care home manager told us that the GPs always offered to telephone or meet residents' relatives to provide them with support and answer any questions they might have about their family member.

The practice's computer system alerted GPs if a patient was also a carer. Good information was available to direct carers to the various avenues of support available to them, both on the practice's website and in the waiting area. This included services for young carers. A carers' champion had been appointed for each branch to ensure information was kept up to date and patients with caring responsibilities were sign posted to the relevant support services. We noted that a

representative from the carers trust had attended one of the practice's fortnightly education meetings to give an update on the latest issues affecting carers. The practice took part in the Carers' Prescription Service. When GPs identified patients in their practice who provided care to others, they could write a prescription for them which could be 'cashed in' by the carer to access a specialist worker at Carers' Trust Cambridgeshire for support, information and respite care. The practice had conducted a specific carers' audit to ensure patients' next of kin data was up to date and the required consents for information sharing were documented.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice offered a number of additional services to patients in addition to chronic disease management including minor surgery, travel vaccinations, family planning and cryotherapy. It also provided anti-coagulation clinics for patients in the locality and also ultrasound services to enable improved access to diagnostics.

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 had been involved in patient pathway redesign in conjunction with the LCG in the areas of atrial fibrillation and dementia care.

We spoke with the managers of two residential care homes who told us that the practice was very responsive to last minute requests for visits, medication or to certify the death of a resident. One told us that the dispensary staff always rang them when a prescription was ready to be collected, something which she valued greatly and meant that residents received their medication quickly.

The practice was able to meet the needs of patients with disabilities. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. The waiting areas were large with space for wheelchairs and prams. A hearing induction loop was also available. Longer appointments were available for those with learning disabilities or mental health needs. A home delivery service from the dispensary was available for patients unable to attend to practice.

There were four male and two female GPs which meant that patients could request a GP of their preferred gender.

Access to the service

Information was available to patients about appointments on the practice's website and in its patient information leaflet and appointments could be booked in person, by telephone or on-line.

The practice's site at Alconbury was open between 8.30am and 12.30pm, and between 2pm to 6pm, Monday to Friday, except on a Tuesday when it closed at 1pm, and on a Friday

when it closed early at 5pm. However, a GP telephone triage service was available until 6.30pm. The practice's site at Brampton was open each day 8.30am to 6pm, except on a Wednesday when it closed at 1pm, and a Friday when it closed at 5pm. However, the practice did not offer any extended hours services although patients could be seen at either surgery. On the day appointments were available, with 12 urgent slots held aside each morning and nine in the afternoon for emergency appointments. Patients we spoke with told us that they were able to get appointments when they needed them.

The practice did not run specific clinics for long term conditions such as diabetes or asthma, preferring to offer patients flexible appointments at times that suited them.

The practice did not offer any extended hours opening times, however results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 74 % of patients were satisfied with the practice's opening hours compared to the CCG average of 76 % and national average of 75%.
- 93% patients said they could get through easily to the surgery by phone (CCG average 76%, national average 73%).
- 92% patients described their experience of making an appointment as good (CCG average 77%, national average 73%).
- 84% patients said they usually waited 15 minutes or less after their appointment time (CCG average 65%, national average 65%).

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns and its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. Reception staff spoke knowledgeably about the practice's complaints procedure. We saw that information was available to help patients understand the complaints system and reception staff gave us

Are services responsive to people's needs? (for example, to feedback?)

information sheets about its own procedure, and also details of how to raise concerns about other health care providers they might use. Details were also available on the practice's website.

We looked at six complaints received in the last 12 months and found they had been fully investigated and responded

to in a timely way. Two of the complaints had been upheld and appropriate apologies had been given to patients. Complaints, including negative NHS Choices feedback were regularly discussed at the GPs' fortnightly meetings, evidence of which we viewed.

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, patients focussed, evidence based medical care'.

Staff we spoke with were aware of this mission statement which was displayed on the practice's web site. We viewed minutes of the staff forum meeting held on 15 July 2015, where this mission statement was discussed and agreed with all present. The practice's forthcoming five year business plan was also discussed, with a commitment given to collect staff's input for it.

We found that practice staff were well aware of future challenges and opportunities, including the need to extend its premises and services to meet a forthcoming increase in patient numbers. One of the practice's GPs sat on the steering group of the West Cambridgeshire Federation, to discuss and plan for future changes in how GP services were to be delivered.

Governance arrangements

The practice had a number of policies and protocols in place to govern its activity and these were available to staff on the practice's computer systems. Staff had signed the policies to indicate that they had read, understood and agreed to abide by them. We looked at a sample of policies and procedures and found that they were up to date and had been reviewed regularly.

The practice wide team across both sites was made up of six smaller teams, each led by a specific supervisor. The clinical team consisted of the GPs, nurses and health care assistants, and the administrative team of the medical secretaries, receptionists and dispensers. These were divided into six smaller teams, each led by a specific supervisor. Named members of staff had specific lead roles. For example, there was a lead nurse for infection control and partners took lead roles for areas such as safeguarding, finance, QOF, medicines and Caldicott principals. Staff we spoke with were all clear about their own roles and responsibilities within the practice.

Communication across the practice was structured around key scheduled meetings. There were fortnightly partners' meetings and quarterly meetings each for administrative staff, medical secretaries and the dispensing team. A practice wide meeting involving all staff was held every six

months which provided an opportunity to review significant events, share learning and discuss any practice wide issues. These meetings were advertised well in advance and minutes were kept.

The practice completed an information governance tool kit every year to ensure it was adequately managing personal information relating to patients and staff. We found that the quality of record keeping within the practice was generally very good, with minutes and records required by regulation for the safety of patients being detailed, maintained, up to date and accurate.

Leadership, openness and transparency

Staff we spoke with clearly enjoyed their job and were enthusiastic about their work citing excellent support, effective communication and good staffing levels as the reason. They described an inclusive and open environment in which their suggestions and views were listened to and valued by senior staff. Several told us about the practice's ALBRAM Award Scheme which recognised good practice amongst the staff team. One nurse reported that she had won the award in recognition of her team leadership skills and had felt very proud as a result.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Minutes of the staff forum meeting minutes we viewed for July 2015 showed that very open and detailed discussion took place regarding recent significant events and complaints.

Members of the practice's participation group reported that they had a good working relationship with the practice manager and the partners, and felt their concerns were listened to and respected.

The practice manager was aware of the need to build relationships between staff and there were regular practice wide social events at Christmas and in summer to promote team building across the two sites.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. There was patient participation group, consisting of about 10 core members, and another 120 as part of its virtual on line group. The group met about four times a

Are services well-led?

Good 

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

year and meetings were always attended by the practice manager and one of the GPs. It was a very active group and ran a patient transport service and raised money to buy equipment for the practice. In response to suggestions from the group, the practice had facilitated patient education meetings on issues such as carers' needs, smoking cessation and with the diabetic nurse specialist.

The practice also participated in the Friends and Family Test (FFT) and the most recent results showed that 405 patients would be extremely likely to recommend the practice, 21 would be likely and only one would neither likely nor unlikely recommend it. Feedback from the FFT was regularly shared with staff at their meetings.

The practice monitored the NHS Choices website closely for patient feedback about its services, and always

responded to comments left on the site. We viewed eight recent reviews and noted that seven of these were exceptionally good, praising the practice for its excellent service.

We also noted boxes in the waiting areas, inviting patients to make suggestions about the service they received.

The practice gathered feedback from staff through practice meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One of the practice's dispensing staff told us that they had been actively consulted about the building of the dispensary including the colour it should be painted, the height of the work benches, and the type of flooring.