Newnham Walk Surgery

Quality Report

Newnham Walk Surgery
Wordsworth Grove,
Cambridge,
Cambridgeshire.
CB3 9HS
Tel: 01223 366811
Website: www.newnhamwalksurgery.nhs.uk

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
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 visited Newnham Walk Surgery on the 4 June 2015 and carried out a comprehensive inspection. Overall the practice is rated as good.

We found the practice to be safe, effective, caring, responsive to people's needs and well-led. The quality of care experienced by older people, by people with long term conditions and by families, children and young people was good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also received good quality care.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored and appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- There was a strong learning culture within the practice. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with dignity and respect and were involved in their care and decisions about their treatment.
- The practice was safe for both patients and staff. Robust procedures helped to identify risks and where improvements could be made.
- The clinical staff at the practice provided effective consultations, care and treatment in line with recommended guidance.
- Information about services and how to complain was available to patients and easy to understand.
- The practice had good facilities and was well equipped to treat patient and meet their needs.
- Services provided met the needs of all population groups.
- The practice had strong visible leadership and staff were involved in the vision of providing high quality care and treatment.

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?

Good

The practice is rated as good for providing safe services. The practice was able to demonstrate that they provided safe services that had been sustained over time. There were processes in place to report and record safety incidents and learn from them. Staff were aware of the systems in place and were encouraged to identify areas for concern, however minor. Staff meetings and protected learning time were used to learn from incidents and clear records had been kept including any action taken. Risks to patients were assessed and well managed. Infection control procedures were completed to a satisfactory standard. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They were aware of their practice population and tailored their services accordingly. Patients were generally satisfied with the appointment system and the availability of the GPs and the nurse. Patients had a choice of GP if they wanted one. Telephone consultations and home visits were available when necessary. The premises were suitable for patients who were disabled or with limited mobility. A prescription service was available for those patients unable to attend the

Summary of findings

practice and a local pharmacy made home deliveries. There was an effective complaints system in place that was fit for purpose, complaints received had been dealt with in a timely and effective manner.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy for the delivery of high quality care and staff were working towards achieving 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 team meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events. We found there was a good level of constructive staff engagement and a high level of staff satisfaction. There was an emphasis on seeking to learn from stakeholders, in particular through the local clinical commissioning group (CCG) and the patient participation group (PPG). This is a group of patients registered with the practice who have an interest in the service provided by the practice.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the population group of older people. Care was tailored to individual needs and circumstances. There were regular 'patient health care reviews' involving patients, and their carers where appropriate. The practice provided medical cover to a local nursing home to review patients medications and complete health checks. Unplanned hospital admissions and readmissions for this group were regularly reviewed and improvements made. Older patients had a named GP responsible for the coordination of their care. The practice held monthly multi-disciplinary team (MDT) meetings attended by GPs, district nurses, practice nurses and when possible midwives, health visitors and community psychiatric nurses to discuss older and vulnerable patients. In addition the MDT coordinator organised monthly meetings of GPs, district nurses, palliative care nurses and administrative staff to discuss older patients and review future care needs. The practice's GP Psychotherapist provided extended appointment sessions for patients who required support, but might not necessarily require referral to secondary care. These covered a wide range of needs including adjustment to a chronic disease, dealing with a new and distressing diagnosis, or discussing the prescribing of a new medicine, anxiety or low mood.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication 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.

The practice's GP Psychotherapist provided extended appointment sessions for patients who required support, but might not necessarily require referral to secondary care. These covered a wide range of needs including adjustment to a chronic disease, a new and distressing diagnosis, discussing the prescribing of a new medicine, anxiety or low mood.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying

and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments with GPs and nurses were available outside of school hours and the premises were suitable for children and babies. The practice provided medical cover and weekly surgeries at a local boarding school. We were provided with good examples of joint working with midwives and community services. Antenatal care was referred in a timely way to external healthcare professionals. Parents we spoke with were positive about the services available to them and their families at the practice. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of 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. For example, the practice had introduced early morning and late evening extended hours appointments during the week and also provided a branch surgery in central Cambridge for patients who travelled in to the city during the week. 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. The practice GP Psychotherapist provided extended appointment sessions for patients who required support, but might not necessarily require referral to secondary care. These covered a wide range of needs including adjustment to a chronic disease, a new and distressing diagnosis, discussing the prescribing of a new medicine, anxiety or low mood. The practice provided vaccination advice and health and sexual health advice to students at the university and liaised closely with the university counselling service.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances might make them vulnerable. Double appointment times were offered to patients who were vulnerable or with learning disabilities. Carers of those living in vulnerable circumstances were identified and offered support which included signposting them to external agencies. Staff knew how to recognise signs of abuse in vulnerable adults and children. A lead for safeguarding monitored those patients known to be at risk of abuse.

Summary of findings

All staff had been trained in safeguarding and were very aware of the different types of abuse that could occur and their responsibilities in reporting it. The practice held monthly multi-disciplinary team (MDT) meetings attended by GPs, district nurses, social workers, practice nurses and when possible midwives, health visitors, school nurses and community psychiatric nurses to discuss vulnerable patients. In addition the MDT coordinator organised monthly meetings of GPs, district nurses, palliative care nurses and administrative staff to discuss vulnerable patients and review future care needs.

The practice's GP Psychotherapist provided extended appointment sessions for patients who required support but may not necessarily require referral to secondary care. These covered a wide range of needs including adjustment to a chronic disease, a new and distressing diagnosis, anxiety or low mood.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with depression). The practice was aware of the number of patients they had registered who had dementia and additional support was offered. This included those with caring responsibilities. A register of dementia patients was being maintained and their condition regularly reviewed through the use of care plans. Patients were referred to specialists and then on-going monitoring of their condition took place when they were discharged back to their GP. Annual health checks took place with extended appointment times if required. Patients were signposted to support organisations and referred to other professionals for counselling and support according to their level of need.The practice GP Psychotherapist provided extended appointment sessions for patients who required support, but may not necessarily require referral to secondary care. These covered a wide range of needs including adjustment to a chronic disease, a new and distressing diagnosis, discussing the prescribing of a new medicine, anxiety or low mood.

Summary of findings

What people who use the service say

The practice had provided patients with information about the Care Quality Commission prior to the inspection and had displayed our poster in the waiting room.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience of the practice with us. We collected 12 comment cards, all the cards indicated that patients were more than satisfied with the support, care and treatment they had received from the practice. Comments cards also included positive comments about the skills of the staff, the treatment provided by the GPs and nurses, the cleanliness of the practice, the support and care offered by staff and the way staff listened to their needs. Patients recorded they were very happy with the care provided and arranged by the practice staff. These findings were also reflected during our conversations with patients during and after our inspection.

We spoke with six patients during our inspection. The feedback from patients was extremely positive. They described their experiences of care and praised the level of care and support they received at the practice specifically identifying members of staff both non-clinical and clinical for the treatment and support given. The patients we spoke with told us they were very happy with the service and they felt their treatment was professional and effective. We were told the GPs and nurses always gave them ample time during their consultation. They told us things were clearly explained to them and clinicians gave them sufficient time and information to be able to make decisions with regard to their treatment and care without feeling pressured. Patients told us that all the team were very supportive and that they thought the practice was very well run. Patients told us if they needed to complain they would speak to the reception team or the practice manager. We were told they felt their concerns would be listened to. Patients told us they were happy with the supply of their repeat prescriptions.

Patients told us they liked the continuity of care they received. Patients also knew they could get a same day appointment for urgent care when required. Patients told us they felt the staff respected their privacy and dignity and the GPs, nursing and reception teams and the practice manager were all very approachable and supportive.

There was a supply of health care and practice information on display in the waiting room area.

Newnham Walk Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC Inspector, a GP specialist adviser and a practice manager specialist adviser.

Background to Newnham Walk Surgery

Newnham Walk Surgery provides general medical services to approximately 12,376 patients and is situated in central Cambridge, Cambridgeshire. The practice also provides medical services to local universities and a boarding school.

The practice has a team of six GPs meeting patients' needs. Four GPs are partners meaning they hold managerial and financial responsibility for the practice. In addition, there is one nurse practitioner, three practice nurses, one health care assistant and a phlebotomist/receptionist. The practice manager is supported by an office manager, a head receptionist and team of medical secretaries, reception and administration staff. Newnham Walk surgery is a training practice and a GP registrar provided clinics throughout the year. Medical students also attended the practice for training.

Patients using the practice had access to a range of other services and visiting healthcare professionals. These included health visitors, midwives, a GP Psycotherapist and Improving Access to Psychological Services (IAPT).

The building provides easy access with accessible toilets. A limited number of car parking facilities are available at the front of the practice and bus stops are available nearby.

Appointments are available from 7am to 6pm Tuesdays, Wednesdays and Thursdays, and from 8am to 6pm on Fridays. The practice opens from 8am until 8pm on Mondays to enable evening access for those who find it difficult attending during working hours. The practice provides on line services which meant patients could pre book telephone consultations appointments and order repeat prescriptions online. Where patients had provided a mobile telephone number the practice provided a text service to confirm when their appointment or telephone consultation would be. There is an informative website with information about the practice, the services that are offered by the practice and links to other organisations.

Outside of practice opening hours a service is provided by another health care provider, by patients dialling the national 111 service. Details of how to access emergency and non-emergency treatment and advice is available within the practice and on its website.

The practice offers a branch surgery at a location in central Cambridge. This provides alternate access to medical services for patients who worked in central Cambridge, students or those patients who were shopping in the city and operated on a daily basis from Monday to Friday from 9am to 4pm with a GP and a nurse offering appointments. We did not visit this location as part of our inspection.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with our regulatory functions. This inspection was planned to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

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.

How we carried out this inspection

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

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

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

- 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)

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. During our inspection we spoke with a range of staff including GP partners, GPs, visiting health professionals, practice nurses, health care assistant, reception and administrative staff and the practice manager. We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. These were located on the practice electronic system and staff demonstrated how to access them.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last seven years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last seven years and we were able to review these. Significant events was a standing item on the practice meeting agendas and dedicated quarterly clinical governance meetings were held to review actions from past significant events and complaints. From this meeting any significant events or complaints where a learning need was identified were referred to the education team and an education meeting was arranged. There was evidence that the practice had learnt from these and that the findings were shared with relevant staff. We found staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked nine incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example with a scanning error where patient information had been inadvertently scanned into the records of another patient. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken, in line with the practice's policy.

National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were disseminated to all clinical staff electronically and discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe to us occasions when they had safeguarding concerns about a patient and the actions they had taken. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children and they had received the appropriate level of training. All staff we spoke with were aware who these leads were and who to speak to both internally and externally if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans, patients diagnosed with dementia or those requiring additional support from a carer.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff told us that nursing staff were mostly

used when chaperoning a patient. Disclosure and Baring Service checks had been undertaken for all clinical and non-clinical nominated staff who had received chaperone training. The management team told us a list was displayed in reception of all staff who were DBS checked and had received chaperone training for clinical staff to refer to if they require a chaperone.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system, which collated all communications about the patient, including scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Medicines management

Medicines were managed safely so that risks to patients were minimised. Medicines were documented, checked and stored correctly. There was secure storage of medicines, including vaccines, emergency medicines and medical oxygen. There was a clear policy for ensuring that medicines were kept at the required temperatures. We saw documents showing that medicines were stored at the appropriate temperature to ensure that they remained effective. The temperatures of fridges used to store medicines were checked daily to ensure that they did not exceed those recommended by the medicine manufacturer. We checked a sample of medicines and these were found to be in the correct quantities and in date. The practice staff followed the cold chain policy when medicines arrived so that they were placed in a fridge as soon as possible.

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. This included the medicines available in the event of an emergency at the practice, the GP's emergency bag used when conducting home visits with patients and stocks of vaccinations used by the nurses at the practice.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. The practice nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The practice nurses also administered medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and health care assistant had received appropriate training and had been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. All prescriptions were reviewed and signed by a GP before they were given to the patient. This included checking whether a medicines review was due before giving it to the patient. A system was in place on the computerised patient record system to identify patients who were due for a review and this was being actioned. The practice had introduced electronic prescribing (ETP2); this enabled the practice to send patients repeat prescription directly to a pharmacy or dispensary of the patients' choice. Making the prescribing and dispensing of medicines more efficient and convenient for patients and staff. Information about this was available to patients at reception, in the practice leaflet and on their website.

Cleanliness and infection control

The practice had an infection control policy and a lead for infection control who had received appropriate training.

We saw that all staff had undertaken infection control training including hand washing guidance so they understood the appropriate technique to reduce the risk of infection. An infection control audit had taken place annually, the most recent audit had been undertaken in April 2015, and this had been completed to a satisfactory standard. This was planned to continue. Where areas for improvement had been identified there was an action plan to ensure completion of the action plan in a timely manner. However we were told where there were financial implications for some actions so these would be addressed when appropriate. There was protective equipment including disposable gloves, aprons and coverings available for staff to use. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Staff told us they liaised closely with the infection control lead for the local clinical commissioning group (CCG) and a visit from the lead had been scheduled to address any issues and provide updates to infection control guidelines.

Good

Are services safe?

Clinical staff had received inoculations against the risk of Hepatitis B. The effectiveness of this was monitored through regular blood tests and records had been kept. Clinical waste was handled correctly and a waste management contractor had been appointed to collect it on a regular basis. It was being stored safely prior to collection. Sharps bins were sited correctly, signed and dated.

The practice had a policy for the management, testing and investigation of legionella. (Legionella is a term for particular bacteria which can contaminate water systems in buildings). We saw the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. However the practice manager advised us they had not received the hardcopy results of these tests from the contractor appointed to undertake them.

We observed the premises to be clean and tidy. This included the consultation and treatment rooms, the reception and waiting area and the toilet facilities. There were adequate supplies of paper towels and liquid soaps for the use by patients and staff. Notices about hand hygiene techniques were displayed in staff and patient toilets. Curtains in consultation rooms were of the disposable variety, and were changed when required or at regular intervals. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We saw that the quality of the cleaning was monitored by the office manager and practice managers and infection control lead.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example spirometers, blood pressure monitors and weight measuring scales.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. We were told this was not written into staff contracts but was discussed at interview. Staff told us there were usually enough of them to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The management team showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

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

Monitoring safety and responding to risk

The office manager showed us the effective systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included portable appliance testing and calibration of equipment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. These included annual and monthly and weekly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

Health and safety information was displayed for staff to see and there was an identified health and safety representative. Staff were able to demonstrate that they were aware of the correct action to take if they recognised risks to patients; for example they described how they would escalate concerns about an acutely ill or deteriorating child or a patient who was experiencing a mental health issue or crisis. Staff at all levels could share

Good

Are services safe?

immediate concerns about risks to individual patients with a clinician. Staff we spoke with said they were confident they could recognise patients who might have acute needs requiring a clinician's input as a priority.

Other systems were in place to monitor risk including medicine reviews for patients, handling national patient safety alerts and dealing with emergencies. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example staff were able to give examples of the actions they would take for patients waiting in the reception area whose health rapidly deteriorated.

Patients suffering from conditions making them more vulnerable were identified and monitored through the use of registers and a multidisciplinary approach with other healthcare professionals. This provided a systematic, organised approach to identify patients at risk of deteriorating rapidly so that care plans could be put in place to support them.

Arrangements to deal with emergencies and major incidents

There was a business continuity plan in place that enabled the practice to respond safely to the interruption of its service due to an event, major incident, unplanned staff sickness or significant adverse weather. The document was kept under review and hard copies were located both on and off-site. The document also contained relevant contact details for staff to refer to and external organisations that would be able to provide the necessary support required to maintain some level of service for their patients.

Identified risks were included on a risk log. Each risk was assessed, rated and control actions recorded to manage the risk. These were discussed at management and GP partners' meetings to ensure any changes in risks were identified, monitored and properly managed.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Staff told us they had received training in fire safety. Fire extinguishers we viewed had all been serviced within the last year to ensure their effective operation if needed. All areas of the practice including treatment rooms had a panic button so that clinicians could summon assistance in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

We found that clinical staff had a system in place to receive relevant updates about new guidelines and these were then put into practice to improve outcomes for patients. There were GP leads in specialist clinical areas such as mental health and diabetes. The nurses supported this work, but led on areas such as childhood immunisations and respiratory care. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes confirmed that this happened.

Patients we spoke with on the day told us that they were satisfied with their assessments and felt that their needs were met by the clinicians. Patients received appropriate advice about the management of their condition including how they could improve the quality of their lives. We saw extensive evidence of comprehensive care planning for patients with long term conditions and those patients receiving palliative care. Anticipatory care planning reflected patients' wishes relating to hospital admission and end of life care. The practice ensured care plans were accessible to other agencies, such as out of hours services to ensure their full involvement and to facilitate sharing of information. The practice referred patients appropriately to secondary and other community care services.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the clinicians had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the Gold Standards Framework for managing patients with palliative care needs who were nearing the end of their lives. Patients were signposted to external organisations that could offer support, such as specialist Macmillan nurses. The practice maintained a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. We looked at the minutes of the palliative care and end of life meetings and found that individual cases were being discussed and care and treatment planned in line with patients' circumstances and wishes.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of

Good

Are services effective?

(for example, treatment is effective)

preventative measures). The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how they, professionally and as a practice, reflected on their performance. Staff spoke positively about the culture in the practice.

The practice had a system in place for completing clinical audit cycles. The practice showed us two clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure improved outcomes for patients. For example, we looked at an audit investigating the prescribing of first line antibiotics across all GPs at the practice. Antibiotics are important medicines for treating bacterial infections. Antibiotic resistance is driven by overusing and inappropriate prescribing. The first audit undertaken from September to October 2014, demonstrated that antibiotics used as secondary line of treatment were being prescribed as a first line antibiotic treatment. Following the first audit the practice's prescribing protocol was reviewed, information was shared with GPs, reminding them of antibiotic formulary guidance. The practice undertook a second audit and reviewed prescriptions for antibiotics during February to March 2015; the audit was able to clearly demonstrate improvement in prescribing for antibiotics across the practice.

Effective staffing

Practice staffing included clinical, managerial and administrative staff. We viewed training records and found that all staff had received annual basic life support and safeguarding of children and vulnerable adults. Staff had also been trained in the use of the equipment used at the practice. Training of all staff was regularly reviewed.

There was an induction programme in place for all new which covered generic issues such as fire safety and infection control. All staff including medical students and GP trainees spent time within all areas of the practice during their induction. Staff described how they had shadowed other staff in the practice during their induction period so they became familiar with how the practice worked. We saw there was a range of non-clinical training for staff that was specific to their role such as training specific for reception or administration staff. There was a system in place to ensure staff received training that was considered by the practice to be mandatory, such as basic life support training, health and safety and safeguarding. Some training was delivered to staff through an online system and they received protected learning time to enable them to complete it. Non-clinical staff were trained to carry out more than one role; for example, administrative staff could carry out reception duties to enable the practice to remain effective during peak times. All clinical staff underwent disclosure and barring checks (DBS) to ensure their suitability for their role. Members of staff who provided chaperone services also underwent DBS checks. The practice displayed a list in the reception area of all staff who were DBS checked and had received chaperone training, clinical staff referred to this list if they required a chaperone.

We saw that all staff could access the practice's policies and guidance electronically from the practice's intranet.

All GPs and nurses were up to date with their yearly continuing professional development requirements and all GPs had either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England).

Staff we spoke with told us they had received regular appraisals which gave them the opportunity to discuss their performance and to identify future training needs. Personnel files we examined confirmed these included reviews of performance and the setting of objectives and learning needs. All of the GPs within the practice had undergone training relevant to their lead roles, such as adult and child safeguarding.

The practice was a training practice and supported the training of medical students and GP trainees. We saw that students were provided with a workload appropriate to their level of training and underwent review and debriefing with a senior GP following all their appointments sessions. Extended appointments were provided and students had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, practice nurses provided smoking cessation advice, cervical cytology and managing

Good

Are services effective?

(for example, treatment is effective)

and supporting patients with long term conditions such as diabetes and administration of childhood and travel vaccines. We saw that the practice nurses and healthcare assistants had been provided with appropriate and relevant training to fulfil their roles.

Staff described feeling well supported to develop further within their roles. We noted a good and loyal skill mix among the reception, administrative and clinical teams.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. GPs reviewed all communications received by the practice. The named GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. We were told there were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. We also saw how the practice spoke with and worked collaboratively with local schools and universities, other hospitals and consultants to the benefit of its patients.

There were regular meetings, involving other different professionals, to discuss specific patients' needs. For example the practice held monthly meetings with a diabetic specialist nurse to review care and treatment of patients diagnosed with diabetes. The practice held monthly multidisciplinary team (MDT) meetings to discuss the needs of complex patients, for example patients with end of life care needs, and children on the at risk register. These meetings were attended by GPs, district nurses, practice nurses, social workers and when possible midwives, health visitors and community psychiatric nurses to discuss vulnerable patients and make decisions about care planning which were documented in a shared care record. In addition the practice liaised with the locality MDT coordinator who organised monthly local meetings of GPs, district nurses, palliative care nurses and administrative staff. We saw minutes of meetings where teams had discussed future care requirements for patients with complex needs. Staff we spoke with told us this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice website provided patients with information about the arrangements to share information about them and how to opt out of any information sharing arrangements.

Electronic systems were also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

We were told a diabetic consultant attended the practice quarterly for education sessions with clinicians. One GP was an accredited trainer and GP appraiser with Cambridge University and one an associate trainer. The practice provided training for students which included foundation year doctors and specialist or general practice training doctors who were training to be qualified as GPs. The practice also worked closely with the university counselling service and details of how students could access this service were advertised on the practice website and in the practice leaflet.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice manager told us the practice made use of NHS referrals last year through the Choose and Book system.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper

Good

Are services effective?

(for example, treatment is effective)

communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

The practice received information from the local GP out-of hour's service when their patients had cause to use it. The record of the consultation was then placed on their electronic system and reviewed by the GP to assess whether a follow-up appointment was required.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. Staff showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

Consent to care and treatment

A consent policy was in place that identified the different types of consent that could be obtained including implied, verbal and written. We found that clinical staff were aware of the Mental Capacity Act 2005; we saw that staff had received training. Staff were also aware of the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). Staff we spoke with were able to give examples of how a patient's best interests were taken into account if they did not have capacity to make a decision. The practice also followed the correct procedures when considering making do not attempt resuscitation orders. This involved support for patients to make their own decisions and how these should be documented in the medical notes.

Clinical and reception staff we spoke with were aware of the consent issues known as Gillick competence. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).They understood that if a child under the age of 16 attended for an appointment with a GP or nurse without a parent or guardian and they indicated that they did not want one present, they would be given an appointment. The GPs we spoke with were aware that they then had to apply the Gillick competency test. Nursing staff were aware of the need to consider whether a person attending with a child had the legal right to agree to consent to treatment on their behalf. This included where child immunisations were due and a child attended with a person that might not be legally entitled to consent to treatment on their behalf, such as a step-relative or grandparent.

Patients we spoke with on the day of our visit told us that they were provided with sufficient information during their consultation and that they had the opportunity to ask questions to ensure they understood before agreeing to a particular treatment.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with one of the practice's nurses to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

Staff showed us and told us about the new patient's registration pack which included a new patient health questionnaire, a medication information questionnaire, consent of patient care data information sharing and an opt out request for patients from the NHS Summary Care Record. Clinical staff told us about the patient consultations where they first met with adults and children and welcomed them to the practice. We were told this was when they discussed with patients their past medical and family histories, medication, lifestyles and/or any health or work related risk factors.

Good

Are services effective?

(for example, treatment is effective)

The practice offered NHS Health Checks to all its patients aged 40 to 75 and these checks were undertaken by the healthcare assistant or practice nurse. The performance of the practice in this area was monitored and data reflected that targets were being achieved.

The computerised record system was used to identify patients who were eligible for healthcare vaccinations and cervical screening. We saw a clear process that was followed for patients who did not attend for cervical smears. We were told this could be challenging due to obtaining previous test results and records from overseas students, however the practice had achieved a 77.6% uptake against a target of 80%.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Due to the practice's location there was a lower than average number of patients under 18 years. We saw that immunisation rates were in line for all standard childhood immunisations. The practice was pro-active in identifying patients eligible for these immunisations, through posters in the surgery, the information screens in reception, letters to patients and telephone calls. Travel vaccinations were also available.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice and on the practice website. This included information about services to support them in doing this, such as smoking cessation advice. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. This included advising patients on the effects of their life choices on their health and well-being.

The practice proactively identified patients, including carers who might need on-going support. The practice offered signposting for patients; their relatives and carers to organisations such as Age UK. The practice kept a register of all patients with dementia and 87.1% had received an annual health review. The practice also kept a register of all patients with learning disabilities and 100% had received an annual health check.

Other health information available for patients included safeguarding vulnerable patients, requesting a chaperone, victim support and support for patients and their carers, this was available on the noticeboards in the reception area. Patients could be referred by a GP to ensure they received appropriate support.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2015 National Patient GP survey and a survey of patients undertaken by the practice's patient reference group (PRG) in 2013/2014. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey sent 411 surveys to patients, there had been a 23% response rate. Results showed the practice was rated 'among the best' at 91% for patients who rated the practice as good or very good in comparison to the clinical commissioning group (CCG) average of 86%. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 97% of practice respondents saying the GP was good at listening to them, 97% saying the nurse was good at listening to them, 89% saying the GP gave them enough time and with 95% saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 12 completed cards and they were all extremely positive about the service experienced. Many referred to specific members of staff and praised the way they had been treated by them. Patients felt the practice offered an excellent service and staff were caring, efficient, friendly and professional. They said staff treated them with dignity and respect and were courteous and respectful. We also spoke with six patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected, again patients made specific reference to named members of both the clinical and reception/administration teams and praised the care, treatment and support they had received from them.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We observed staff treated patients with respect and were quick to offer support and assistance where required.

The practice had a range of anti-discrimination policies and procedures and staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the business or practice manager. The practice manager and office manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

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

The results from the 2015 National Patient GP survey which we reviewed showed that patient's' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 92% of respondents said the GP was good at explaining treatment and results and 90% that the GP involved them in decisions about their care and treatment.

Patients we spoke with on the day of our inspection told us that they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that the GPs were caring, took their

concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we received was also overwhelmingly positive and each of the six patients we spoke with told us that they were happy with their involvement in their care and treatment.

Staff told us that the vast majority of patients registered with the practice were English speaking. They told us that translation services would be made available for patients who did not have English as a first language. An electronic appointment check-in system, was available to reflect the most common languages in the area. Staff had access to an interpretation and translation service.

Patient/carer support to cope emotionally with care and treatment

Patient feedback on the comment cards was very positive regarding the care staff showed to patients and their carers. Staff we spoke with showed awareness and empathy for patients, they were able to describe to us and we saw examples of how they supported patients when required.

Notices in the patient waiting room and practice website also told patients how to access a number of support groups and organisations. The practice computer system alerted GPs if a patient was also a carer.

The practice had a system for ensuring that all staff were informed of the death of a patient. This was to reduce the risk of any inappropriate contact by the practice staff following the death, for example issuing a letter in the name of the patient. Patients were supported by the practice when a close relative died. The waiting area included information sign posting people to support available including counselling and bereavement services. A named GP visited patients towards the end of their lives and supported family members alongside the community matron and nursing team. Traumatic events such as a death or loss of a child during pregnancy were identified and support offered including signposting to other services. If the service was unable to meet the patient's needs they could refer the patient to trained counsellors and mental health support. Staff we spoke with said that patients at the end of their life and their family were provided with whatever support they needed. Staff told us that if families had suffered bereavement, their usual GP contacted them. 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. We didn't speak to any patients who had recently experienced bereavement, however those we did speak with told us the practice provided good support and staff were kind and helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and clinical commissioning group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice offered a branch surgery at a location in central Cambridge. This provided alternative access to medical services for patients who worked in central Cambridge, students or those patients who were shopping in the city. It operated on a daily basis from Monday to Friday from 9am to 4pm with a GP and a nurse offering appointments. We were told patients found this easy to access due to the bus services and multi-storey car parking nearby.

The practice also provided numerous in house services and tests that would normally be undertaken in hospital. For example, since 2011 the practice offered extended (up to 45 minute) appointments with a registered GP who was also a qualified psychotherapist. This allowed the GPs to refer patients for support who would not necessarily require or be appropriate for referral to secondary care services (hospital). The GPs provided a flexible system in that there was no formal referral, patients were informed of the service and invited to make an appointment with the psychotherapist should they choose to. Patients were free to make as little or as much use of this service as they wished. The practice had audited patient usage of this service and in 2014 had produced a patient satisfaction questionnaire. We were told they had received 100% response to the survey with only one unfavourable comment. Ease of access and lack of waiting times were cited as positive outcomes.

The practice also hosted weekly midwifery and fortnightly health visitor clinics at the surgery. These services meant patients could be treated closer to home and this was of significant benefit due to the population of the area. The practice also provided other in house procedures including minor surgery and minor injury which was again particularly useful as the practice saw transient patients due to its close location to the cities universities.

The national GP patient survey indicated that 86% of registered patients who responded were satisfied with the telephone access compared with 73% nationally and 76% regionally. This indicated the practice was better than the national and CCG average.

The practice had referral criteria that helped clinicians to make timely referrals after relevant investigations and tests had been performed. There were arrangements to refer or transfer patients to another service so patients' needs were met at the right time. These could be secondary referrals to specialist clinics such as diabetes, chronic obstructive pulmonary disease (COPD) or mental health as an example. Homeless patients were referred to the Cambridge Access Surgery, a specialist service set up to meet the specific needs of homeless people in Cambridge. The practice manager told us due to the location of the practice they did not have any known travellers, migrant or sex workers in the area.

We saw that the practice had an active Patient Participation Group (PPG), a group of patients registered with a practice, who work with the practice to improve services and the quality of care. We saw that feedback provided by the PPG were listened to and implemented where appropriate. For example we spoke to three members of the PPG and all stated they had positive experiences of the practice responding to their needs. However, one of the members of the PPG stated they would like the dates and times agreed in advance for the meetings and felt the arrangements for arranging were very ad-hoc at present.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of patients living with dementia. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review. Moreover, we saw that the practice ran regular checks of the data on their patient record system to identify patients with a range of factors that were particular indications of a learning disability or of dementia so that they could benefit from this service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was configured in a way that enabled patients in wheelchairs to access their GP. There was level access throughout with widened doorways and accessible toilets. The practice had a hearing loop installed in reception and a system in place to support patients with reduced hearing when telephoning the practice. The practice had access to online and telephone translation services and double appointments were offered to patients who required an interpreter. Patients who were not permanent residents could access the service by either registering as a temporary resident or if their need for medical treatment was immediately necessary.

Over half the practice patient population were students and due to the close proximity of the Cambridge universities there was a high turnover of these patients. Along with the rest of the adult population the practice had put systems in place to address the needs and demands of this population group. For example the practice offered a diverse range of appointments including unlimited acute appointments each day to ensure any daily demand was fully met along with extended hours appointments several times a week and the use of text messaging to confirm appointments, send reminders and invitations for vaccinations and smoking cessation advice. One GP described the increased levels of need for students with regard to busy and stressful terms. The GPs had a wide range of special interests including mental health, family planning, sexual health and muscoskeletal problems. This ensured that the practice could respond to the psychological and medical needs of the student population. The practice offered long (up to 45 minute) appointments with a registered GP who was also a qualified psychotherapist. Staff could access a translation service for patients whose first language was not English.

Access to the service

One GP told us the practice had a long history dating back to before the start of the NHS and served a population dominated by the provision of care to the university, students and staff alongside the local residential population. The surgery was purpose built in an urban residential area, close to the universities. The practice provided some car parking facilities, but had limited room for extension. There was a ramp to access the surgery. Treatment and consultation rooms were located on the ground floor.

Appointments were available from 7am to 6pm Tuesdays, Wednesdays and Thursdays and from 8am to 6pm on Fridays. The practice opened from 8am until 8pm on Mondays to enable evening access for those who found it difficult to attend during working hours. The practice provided on line services which meant patients could pre book telephone consultations appointments and order repeat prescriptions online. Where patients had provided a mobile telephone number the practice provided a text service to confirm when their appointment or telephone consultation would be. There was an informative practice website with information about the services that were offered by the practice and links to other organisations.

We saw evidence that the GPs fully engaged with the local emergency care centre to appropriate triage patients. We saw through the use of the same day appointments, telephone consultations and the availability for home visits that patients had a range of options to access services.

The practice ran clinics for people with long term conditions. Midwife and Health visitor clinics were also available at the practice. Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

The practice gave priority to patients with emergencies and to children. Some appointment times were blocked off for this purpose. They were seen on the same day where necessary. Patients could select their GP of choice if they were available. Chaperones were readily available for patients to use on request. We saw how staff supported patients who were vulnerable when they attended the practice. Patients were supported by staff from the time they arrived at the practice to ensure they received the appointment they required. Staff offered guidance and advice to patients during their visit to the practice and were quick to respond to patients or visitors who needed support.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This out of hours service was provided by an external provider contracted by the clinical commissioning group (CCG). Details of how to contact the out of hours provider were available on the practice website as well as in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Telephone consultations were carried out by the duty GP. The patient was able to discuss their concerns with the GP on the telephone and where necessary the GP would provide an appointment on the same or on a more appropriate day.

There were health promotion clinics and screening available, such as for cervical smear, chlamydia and smoking cessation. Signs were available in the reception and waiting room area that explained the appointment system. It also explained how to obtain emergency out of hour's advice through the 111 system.

Patients were usually allocated ten minute appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients suffering from poor mental health or those with complex needs. Patients with learning disabilities were given a double appointment where necessary to ensure all healthcare needs could be adequately discussed during their consultation. Staff told us appointments with the practice GP Psychotherapist were scheduled for 45 minutes if required.

A system was in place so that older patients and those with long term conditions could receive home visits or telephone consultations. Time was set aside each day to manage these consultations. Patients who were housebound or with limited mobility could receive home visits and these were identified on the patient record system.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances.

Patients were very satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had regularly been able to make appointments on the same day of contacting the practice.

GPs provided weekly ward rounds to a local nursing home as well as attending the home for any urgent patient medical needs. The practice also provided medical services to students at a local boarding school including weekly visits to the school. The practice kept a number of bicycles and cycling safety equipment for GPs and nurses to use for ease of home visit access in the urban area.

Repeat prescriptions were dealt with on the same day by a dedicated member of staff; we saw this process in place together with effective steps being taken when these were collected. The process was robust and ensured timely issuing of repeat prescriptions with adequate security on collection.

Listening and learning from concerns and complaints

The practice had a 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.

Information on how patients could make a complaint was available to patients in a number of areas; including the practice website and practice leaflet.

The practice had received nine complaints in a nine month period from August 2014 to April 2015. Records showed complaints had been dealt with in a timely way and the practice's responses were open and transparent. There was an active review of complaints and where appropriate improvements made as a result. Positive feedback from patients was also shared and celebrated among the staff.

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 GPs and management team had a clear vision and purpose to deliver high quality medical care to its patients in a friendly and professional manner. The GPs we spoke with were able to demonstrate a clear understanding of their role and responsibility within the practice. We saw that all staff took an active role in ensuring provision of a high level of service on a daily basis. There was a defined structure and each department had a manager or supervising head who reported to the practice manager and to the partners on certain clinical issues. Staff spoken with were clearly aware of the direction of the practice and were working towards it. Staff job descriptions and appraisals supported the direction in which the practice wished to head and they were clearly linked to the vision and objectives of the partnership. Staff told us they felt involved in the future of the practice and embraced the principle of providing high quality care and treatment.

Governance arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical commissioning group (CCG) that the service was operating safely and effectively. There were clearly identified lead roles for areas such as safeguarding, prescribing and clinical audits. These responsibilities were shared between the GP partners. In addition, one of the GPs represented the practice on the locality group within the CCG area, a group of practices that met to monitor and direct local primary care services.

The practice used a number of processes to monitor quality, performance and risks. For example, the practice actively ran regular searches through the quality and outcomes framework (QOF) to help them to manage their performance and to assess their quality and productivity. The practice also actively used feedback from complaints, concerns and the findings of significant event analyses (SEA), clinical audits and referral peer reviews to understand and manage any risks to their service. We looked at a number of examples of each of these as previously reported above. The practice had comprehensive quality assurance and risk management arrangements in place. Examples of these included the use of National and International studies, staff supervision, peer review (internal and external) to the practice and effective systems and processes for patient recalls and medicine management. Staff had lead roles in managing QOF and performance was closely monitored. Comprehensive arrangements were in place for identifying, recording and managing risks, internal and external to the practice.

Decision making and communication across the workforce was structured around key, scheduled meetings as well as benefitting from some informal and more dynamic dialogue between staff. The partners and the practice manager met at monthly management meetings to discuss the business and the things that had an impact on its effectiveness. These included QOF data, clinical audits, significant event analysis and complaints. For example, we looked at the notes of the meetings at which the practice's performance in relation to prescribing and unplanned hospital admissions were discussed.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and a lead for safeguarding, within the practice. Clinical staff also had lead roles in relation to their clinical expertise. There was a lead GP for a number of medical conditions for example asthma, diabetes and women's health. The staff we spoke with were aware of their own roles and responsibilities and knew who had lead responsibility in the practice for other areas.

We saw from the minutes we looked at that staff meetings were held regularly. Staff we spoke with told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings or clinical meetings as appropriate. There was a willingness to improve and learn across all the staff we spoke with. Staff told us they felt the leadership in place at the practice was consistent and fair and generated an atmosphere of team working.

We saw that the practice had an active and engaged patient participation group patient participation group (PPG) to promote and support patient views and participation in the development of services provided by the practice. PPGs are a way for patients and GP surgeries to work together to improve services, promote health and

Are services well-led?

Good

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

improve quality of care. We saw that the PPG were able to feedback into the surgery patients' views and concerns. We saw an example of where the practice had responded to feedback regarding a carpet requiring cleaning.

We looked at results of the latest national GP patient survey which showed that patients would recommend the practice with 82% responding positively as opposed to a national average of 78%. The most recent results of the Friends and Family test showed 100% of patients responding would recommend the practice. The latest test showed five patients had responded.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through practice surveys, compliments and complaints received. The practice monitored feedback from patients in other ways such a comments box, review of the national patient survey and the Friends and Family Test. (This is a tool that provides patients with the opportunity to feedback on their experiences of a service, with the intention that it will stimulate improvement across the NHS). We saw the practice ran an on-going patient survey throughout the year and encouraged patients to participate. Access to the survey was available on the practice website and in the practice waiting room. The practice manager told us the results of the surveys were collated and reviewed with the Patient Participation Group (PPG). Results were published in the practice and on the practice website.

The practice had an active PPG. The PPG included limited representation from all population groups; it was mainly representative for the patient group of older people. We were told the PPG had attempted to attract other patient groups in particular from the student population group, repeatedly through leaflets and word-of-mouth, but had received a poor response rate.

The PPG informed us they met bi-monthly where possible and at least one GP would always attend and listen to feedback. The PPG had carried out surveys and told us that they found that practice staff were open and answered questions directly and openly. For example, we were told that the practice patient surveys had been undertaken each January for the past four years. However we were told this was due to change to a five year survey. We saw that improvements had been made following feedback from the patient's' survey. These included; actively trying to recruit more members to the PPG and training for reception staff with regard to urgent appointments and customer care. The PPG representative we spoke with felt they were able to make suggestions and express their views to the practice and that these were taken seriously and listened to. Members of the PPG also oversaw the PPG display boards in the reception/waiting area of the practice, supported the practice with the annual surveys and supported patients to complete forms. Members of the PPG also attended the local clinical commissioning group (CCG) PPG meetings and cascaded any information from the meeting to the practice and group. The action plan from the results of the 2014 survey included comparison of year on year survey results, comparison to be made with local health surveys, GP appointment availability and telephone access to the practice.

The PPG worked with the practice to provide educational events, these included topics such as first aid and carers. On 10 April 2015 the PPG organised an information session at the practice on Living with Depression. A GP and Psychotherapist presented to patients and visitor who contributed questions and comments.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff on the practice intranet and the staff we spoke with said that they would feel confident in reporting any concerns.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. This was supported by a proactive approach to training and staff development as evidenced by the supportive appraisal system and opportunities for learning through protected learning time.

The practice also had a learning culture that enabled the service to continuously improve through the analysis of events and incidents and the use of clinical audits. Staff at all levels were encouraged to escalate issues that might result in improvements or better ways of working. This showed that the practice had a dynamic and responsive approach to seeking opportunities to learn and improve.