Doddington Medical Centre

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.

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Summary of findings

Overall summary

Doddington Medical Centre provides a range of primary medical services to approximately 4400 patients living in Doddington, Wimblington, Stonea and Benwick.

We found that the practice provided a safe, effective, caring, responsive and well led service. The practice had proactively influenced commissioning decisions to help patients receive care closer to where they lived, rather than travelling to hospital or other health care settings.

All of the patients we spoke with during our inspection, and received feedback from, made extremely positive comments about Doddington Medical Centre and the service they provided. The staff told us that they felt supported.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS local area team about the practice. The information they provided was used to inform the planning of the inspection.

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

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The services at Doddington Medical Centre were safe. The practice were able to demonstrate they had a safe track record. There was effective recording and analysis of significant events and lessons learnt were always shared with relevant staff. There were robust safeguarding measures in place to help protect children and vulnerable adults. The systems in place to manage medicines in the practice were safe.

Are services effective?

The services at Doddington Medical Centre were effective. There were systems in place to ensure that treatment was delivered in line with best practice standards and guidelines. The practice had carried out a number of completed clinical audit cycles and positive outcomes for patients had resulted. There was evidence of multi-disciplinary working. Staff were trained and supported to undertake their role effectively.

Are services caring?

The service at Doddington Medical Centre was caring. All the patients we spoke with during our inspection were highly complimentary about the practice. All the patients who completed a comment card in the weeks before our inspection were extremely positive about the care they received. We saw that staff interacted with patients in a caring and respectful way.

Are services responsive to people's needs?

The practice was responsive. The practice had proactively influenced commission decisions to help patients get care closer to where they lived, rather than travelling. Patients told us that the appointment system at the practice worked well and that they could see the doctor for a routine or urgent appointment without delay. We found there was a longer wait to see a nurse. There was an open culture within the organisation and a clear complaints policy.

Are services well-led?

The practice was well-led. There was a clear vision and purpose and staff were aware of their responsibilities in relation to this. Staff felt supported by management. There were systems in place to monitor and improve quality and identify risk. The practice had an active patient participation group (PPG).

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 supported patients and carers to receive coordinated, multi-disciplinary care. The GPs met every two weeks with other members of the multidisciplinary team to review patients at the end of their life, patients with complex needs and to minimise unplanned admissions. A weekly surgery for patients living in a sheltered accommodation facility nearby at Doddington Court was undertaken as well as a weekly multidisciplinary meeting for patients in the intermediate care beds at Doddington hospital.

Patients aged 75 and over had a named GP who was responsible for the overview of their care.

People with long-term conditions
The practice supported patients and carers to receive coordinated, multi-disciplinary care whilst retaining oversight of their care. A system was in place to regularly review patients with long term conditions and patients who did not attend were followed up. A Diabetes Consultant reviewed patients who found it difficult to follow advice during quarterly visits to the practice.

Mothers, babies, children and young people
Health screening and health promotion literature was available for this group, for example, chlamydia screening. The GPs undertook a postnatal check six weeks after the birth of a baby. New patient checks for 'looked after' children and young people (those children and young people who are looked after by the state/local authority) were undertaken by the GP.

The working-age population and those recently retired
The practice did not offer extended opening hours although if a patient was unable to attend during surgery hours they were seen after surgery hours at the practice. Patients could consult the doctors by telephone rather than visiting the surgery. Patients were offered a choice when they were referred to other services.

People in vulnerable circumstances who may have poor access to primary care
The practice had identified patients with learning disabilities, although there was no evidence that annual health checks had been completed or offered. There were no barriers to patients accessing services at the practice.

Summary of findings

People experiencing poor mental health
Doctors had the necessary skills and information to treat or refer patients with poor mental health. An Improving Access to Psychological Therapy (IAPT) service was provided on a weekly basis at the practice.

Summary of findings

What people who use the service say

We spoke with 10 patients during our inspection. They told us that they were involved in decisions about their care and treatment and they were treated with dignity and respect. They were particularly complimentary about the genuine caring and helpful attitude of both the clinical and non-clinical staff. Patients also told us that they were involved in decisions about their care and treatment, were listened to and were treated with dignity and respect. Two patients told us there could be a long wait in the waiting room whilst waiting to be seen for a booked appointment, but they did not mind this because the doctors provided a thorough consultation.

We collected seventeen Care Quality Commission comment cards from a box left in the practice in the week before our inspection. The majority of the comments on the cards were extremely positive about all aspects of the practice and in particular the sound clinical care. The only negative comment we received, which two patients commented on, was about the new chairs in the waiting room, which they felt reclined too far.

We reviewed the annual patient survey dated December 2013, to which 254 patients had responded. The results showed the practice had received an 88% satisfaction rate for services provided and 40% of these were rated as excellent. The two areas where the practice scored lower than the national average for practices of a similar size, were for telephone access and opening hours.
The patient participation group (a group of patients registered with the practice who work with the practice to improve services, promote health and improve quality of care), and the practice had reviewed the results and developed an action plan to address these areas. We saw evidence that where it was possible, all of the actions had been completed. The practice would like to recruit another GP; however consultancy room space was limited making this difficult to be implemented. The patient participation group members we spoke with told us that the support from the practice for the patient participation group was extremely good.

Areas for improvement

Action the service SHOULD take to improve

- The process for the induction of new staff to the practice should be formalised and documented.
- Annual health checks for people with a learning disability should be offered and recorded when they are completed.
- All staff should be aware of the complaints policy.

Outstanding practice

Our inspection team highlighted the following areas of outstanding practice:

- The practice has led the way and proactively influenced commissioning decisions over a number of years to help patients get care closer to where they lived, rather than travelling. This included the following services for example, which were available at the practice, improving access to psychological therapies (IAPT), Abdominal Aortic Aneurysm (AAA) Screening (an abdominal aortic aneurysm is a weakening and expansion of the aorta, the main blood vessel in the body), community ultrasound service, International normalisation ratio (INR) (anti coagulation) clinics with immediate testing, results and treatment, D Dimer testing (a specialised blood test used to detect pieces of blood clot that have been broken down and are loose in the bloodstream), a sleep apnoea clinic in conjunction with Papworth Hospital, an audiology clinic, where hearing tests were performed at the practice to avoid unnecessary referrals and a formalised Deep Vein Thrombosis (DVT) pathway which had led to a reduction in admissions to hospital.
- The practice had GP responsibility for patients admitted to nine intermediate care beds with facilities, including physiotherapy, occupational therapy and nursing. There was a focus on

Summary of findings

enablement which was led by one of the GPs, and palliative care, led by another GP. We saw evidence of positive impact, which included for example, a reduced length of stay in an acute hospital, admission avoidance and increased patient satisfaction for patients, including patients at the end of their life, and their carers, as care was provided closer to home. The practice provided this service to patients from other areas where their usual practice refused to visit them as they were out of the area. Patients using the intermediate care beds were temporarily registered with the practice.

- Patients could request to have permanent online access to their medical records, from the date of this being requested. Whilst this is going to be a requirement for all practices in the future, this was already available at Doddington Medical Centre.
- The GPs sent a bereavement card to relatives on behalf of the staff, when a patient had died.

Doddington Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Doddington Medical Centre

Doddington Medical Centre, in the Peterborough and Cambridgeshire clinical commissioning group (CCG) area, provides a range of alternative primary medical services to approximately 4400 patients living in Doddington, Wimblington, Stonea and Benwick.

There is a dispensary at the main practice. The practice used to have a branch surgery which had a dispensary at Wimblington, but this has closed as the premises were deemed by the practice to be unsuitable. Plans are in place for a new branch surgery, with a dispensary, at North Witchford Lodge, Wimblington, although at the time of the inspection the date for this opening was not known. Until this is open, the practice have arranged for a dispenser to attend North Witchford Lodge between 12:30 pm and 1:30 pm every week day so patients are able to collect their prescriptions and hand in repeat prescription requests.

The practice has a lower proportion of patients under 18 and a significantly higher proportion of patients aged over 65 compared to the CCG and England average. The deprivation score and income deprivation affecting children score is lower than the CCG average and significantly lower than the England average. Income deprivation affecting older people is lower than the CCG and England average.

There are three GP partners, who provide 22 sessions per week. There are three nursing staff, a health care assistant, four dispensary staff, two receptionists, one administration staff and a practice manager.

Why we carried out this inspection

We inspected Doddington Medical Centre as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the service and other information that was available in the public domain. We also reviewed information we had received from the practice and asked other organisations to share what they knew about the practice. We spoke with a representative from one care home where patients were registered with the practice.

We carried out an announced visit on 27 August 2014 between 8:30am and 6:30pm.

During our inspection we spoke with a range of staff, including three GPs, two nurses, two dispensary staff, reception and administration staff and the practice manager.

We spoke with two members of the patient participation group (PPG). PPGs are a way for patients and GP surgeries to work together to improve services, promote health and improve quality of care.

Detailed findings

We also spoke with 10 patients who used the service and talked with carers. We reviewed 17 comments cards where patients had shared their views and experiences of the practice. We observed how people were being cared for and reviewed the treatment records of patients.

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

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

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

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

Are services safe?

Our findings

Safe track record

The practice was able to demonstrate that it had a safe track record. There were clear accountabilities for significant event reporting, and staff were able to describe their role in the reporting process and were encouraged to report incidents. We saw how incidents were recorded and investigated. The partners held an annual meeting to review the practice's safety record over the previous year. This included a review of significant events, deaths occurring on the premises, suicides, any patient sectioned under the Mental Health Act, child protection cases and any near misses.

We saw that there was a robust procedure in place to ensure that safety information was shared appropriately within the practice. Staff were informed of safety alerts and National Institute for Health and Care Excellence (NICE) guidance. We saw evidence that safety alerts had been disseminated and appropriate action had been taken and recorded.

Learning and improving from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed three significant events, two of which were dispensing errors and the other a clinical issue. These had been reviewed, and discussed in the monthly clinical governance meeting which was attended by all staff at the practice. There was evidence of investigation and learning, as improvements had been made to practice.

Reliable safety systems and processes including safeguarding

The practice had a system in place to ensure that patients were safeguarded against the risk of abuse. We reviewed their safeguarding adults protocol and a child protection protocol and guidelines. Additional guidance was available for staff which included for example, an adult abuse referral form and contact information for safeguarding professionals. Staff we spoke with had an understanding of the different types of abuse and how they would respond if they had a concern. There was a separate GP lead for safeguarding children and vulnerable adults.

We saw there was notice in the waiting area and in each of the clinical and consultation rooms advising patients that they could ask for a chaperone. Patients we spoke with confirmed they had received a chaperone, when they had requested one. Clinical staff at the practice acted as chaperones.

Monitoring safety and responding to risk

We reviewed the health and safety policy, and health and safety risk assessment for the practice. Actions had been undertaken to minimise the risks identified, where possible. For example, the practice told us that the car park was not large enough and that patients had to park their car on the road, which was not ideal due to the fast moving traffic. They had tried numerous ways to obtain additional parking facilities but this had not been successful. We saw evidence that plans were in place to refurbish the car park.

A fire risk assessment had been undertaken in July 2014 and many of the actions required had been completed. We saw documented evidence of practice fire evacuations. These were undertaken regularly and staff knew of the actions to take in the event of a fire.

Staff recognised and knew how to respond to urgent and emergency situations. There were appropriate and sufficient emergency medical equipment and medicines available, which were all in date. This included oxygen, an automated external defibrillator and an oximeter, including one for paediatric use. An oximeter is used to measure the amount of oxygen in the blood. An anaphylaxis kit was available in each clinical and consultation room. This is used to provide emergency treatment in the case of severe allergic reaction. All staff were up to date with cardiopulmonary resuscitation (CPR) training and using an automated external defibrillator. This training was provided to all staff in the practice annually.

Medicines management

We noted the dispensary was well organised and operated with adequate staffing levels. There were a range of standard operating procedures (SOPs) for dispensing staff. SOP's are written work processes that explain a procedure from start to finish. These help to ensure all staff members work in a consistent and safe way.

Acute and repeat prescriptions were authorised by the GP electronically before they were dispensed and there was a clear audit trail for this. These prescriptions were then signed at lunchtime or by the end of the working day, after the medication had been dispensed. There was no standard operating procedure for this, however when we

Are services safe?

raised this with the practice manager they advised they would write one. The prescriptions for controlled medicines were always signed by a GP before they were dispensed and there was a standard operating procedure for this.

Patients told us they were happy with the supply of their repeat prescriptions and reported no delays in obtaining their medicines. We observed that staff were helpful to patients and handed them their medicines following safe procedures by checking their identity. We were told that there was a daily delivery of repeat medicines to patients who lived nearby at Doddington Court (sheltered accommodation) who self-medicated, in order for them to maintain their independence.

We looked at records of temperatures for medicines requiring refrigeration. These were recorded daily and were within the recommended range. Staff we spoke with were aware of the action to be taken if the temperatures were out of range. The practice nurse on duty described adequate arrangements for maintaining the cold-chain for vaccines following their delivery.

We checked four drugs from the controlled drug register against the controlled drug stock and found that these matched. We checked the medicines that were kept in GPs bags and found these were appropriate and in date.

Cleanliness and infection control

We observed that all areas of the practice were visibly clean. Hand washing facilities were available and we saw posters were displayed promoting good hand hygiene. Patients we spoke with said they were satisfied with standards of hygiene at the practice.

The practice had a lead nurse for infection control, who had undertaken formal training in this area. The lead nurse worked with the cleaner to develop the cleaning schedules. We viewed the cleaning schedules and found they were up to date and were audited. There was evidence that environmental audits were undertaken and any actions needed were discussed at the monthly clinical governance meeting.

The practice had assessed the potential risks for legionella and found there was no requirement for a formal risk assessment.

Staffing and recruitment

There was a safe recruitment process in place and each member of staff had a Disclosure and Barring Service check to help ensure their suitability to work with vulnerable patients. The practice manager had a system in place for checking and recording the registration status of the clinical staff annually. This included checking the registration of the nursing staff with the Nursing and Midwifery Council, and the GPs with the General Medical Council.

The right staffing levels and skill mix was sustained at all hours the service was open to support safe, effective and compassionate care and levels of staff well-being. The practice explained how they had identified the need for a health care assistant a few years ago and had supported and trained them to undertake this role, according to the needs of the patients. Due to the health care assistant going on maternity leave, the practice had increased the part time nursing and administration staff hours, with their agreement, to ensure the service to patients was maintained.

We were told by the practice manager that some of the staff had been at the practice for many years and had experience of working in a range of roles at the practice. Staff were paid overtime to cover annual leave and if there were staff shortages, then the remaining staff covered for each other. The staff we spoke with confirmed that this would happen.

Dealing with Emergencies

There was a disaster recovery plan available which identified the severity and likelihood of a range of risks, and actions to take in the event of those risks occurring. For example, clerical and management routine procedures were documented so that other staff could undertake these roles if needed. The staff we spoke with were aware of the disaster recovery plan and were provided with a copy of it to keep in their staff file. A copy was also kept off site.

Equipment

We saw the practice was suitably equipped with the necessary equipment to help clinicians investigate and diagnose an extended range of conditions patients might present with. The equipment was in good order and there was evidence that it had been regularly recalibrated if necessary. The practice and facilities were accessible for people with limited mobility.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice used National Institute for Health and Care Excellence (NICE) guidance to ensure the care they provided was based on latest evidence and was of the best possible quality. Patients received up to date tests and treatments according to their needs. We were told that revised NICE guidelines were identified and shared with all clinicians appropriately. In addition to the NICE guidelines, the practice also followed the Scottish Intercollegiate Guidelines Network, (SIGN) guidelines for people with long term conditions. The Scottish Intercollegiate Guidelines Network (SIGN) develops evidence based clinical practice guidelines for the National Health Service (NHS) in Scotland.

The clinicians we spoke with confidently described the processes to ensure that written informed consent was obtained from patients whenever necessary. We were told that verbal consent was recorded in patient notes where appropriate and we saw evidence of this. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Clinical audit is a process or cycle of events that help ensure patients receive the right care and the right treatment. We looked at three completed clinical audit cycles, one for gout, another for hypnotic prescribing and another for antipsychotic prescribing for dementia. We saw evidence of continued learning which resulted in improved, positive outcomes for patients.

Doctors in the practice carried out minor surgical procedures in line with their Care Quality Commission (CQC) registration under the Health and Social Care Act (2008) and NICE guidance. We were told by the practice manager that the GPs who undertook these were appropriately trained and kept up to date with the latest safe practice and guidance. They also regularly audited their results and used these in their learning and development.

The practice was participating in a national initiative to reduce unplanned admissions to hospitals among its patients. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess effectiveness.

Effective staffing, equipment and facilities

We found that staff were given support and guidance to ensure they were able to undertake their role safely and effectively. There was an information pack available for locum GPs. New staff we spoke with confirmed they had received an induction, which included shadowing opportunities; however this was not documented.

There was a spread sheet of training which was deemed mandatory by the practice and the staff we spoke with showed us their completed certificates. We found that staff had undertaken additional training appropriate to their role and this was supported by the practice. Staff we spoke with said they were supported and competent in their role.

We spoke with a range of staff who confirmed that they received annual appraisals. We looked at three staff members' files and the records we saw supported this. We saw evidence of the practice responding to staff need and managing staff performance.

Working with other services

Patients were able to have access to their medical records and were asked for their consent to share their medical records with other services. There was effective information sharing for example with the out of hours provider and district nurses. We saw that information regarding patients who were at the end of their life was shared with the out of hours provider. This ensured that care and support would be seamless if the patient needed a GP out of hours. The Diabetes Consultant reviewed patients who found it difficult to manage their condition, during quarterly visits to the practice. We saw that the practice had developed good relationships with these services. There were some difficulties with the support received from the local community trust in relation to liaison with midwives and health visitors, which the practice were trying to resolve.

Are services effective?

(for example, treatment is effective)

One of the GPs led a multidisciplinary meeting each week for patients who were staying in the intermediate care beds. This was followed by a weekly surgery for patients who lived at Doddington Court, which was a sheltered accommodation facility. The GPs met every two weeks with other members of the multidisciplinary team to review patients at the end of their life, patients with complex needs and to minimise unplanned admissions.

Health, promotion and prevention

There was a large range of up to date health promotion information available at the practice.

We saw that new patients were invited into the practice when they registered to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and health screening. This enabled the clinicians to assess new patients' risk factors. New patient checks were mainly undertaken by the nurse, although new patient checks for looked after children (those children and young people who are looked after by the state/local authority) were undertaken by the GP.

We looked at the Quality and Outcomes framework (QOF) data, which is an annual incentive programme designed to reward good practice. The practice scored positively across the majority of the indicators. Patients were encouraged to take action to improve and maintain their health and were advised of the effects of their life choices on their health and well-being. The practice QOF data was positive, particularly in relation to smoking cessation advice and for completing a physical health check for patients with severe mental impairment within the previous 15 months, when compared to other practices in the same CCG area.

The practice kept a register of patients with a learning disability; however they were unable to provide evidence that patients with a learning disability had received an annual health check in the previous 12 months.

The practice identified patients who were also carers. Staff and clinicians were automatically alerted to patients who were also carers. This ensured that doctors were aware of the wider context of the patients' health needs. Information was available for carers in the entrance area of the practice.

The practice proactively identified people who needed extra support in relation to health promotion and the prevention of ill-health. For example, the practice visited all care homes and housebound patients in the identified age group for the shingles vaccination. This resulted in a very high uptake of the shingles vaccination.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a strong, visible person centred culture and staff and management were fully committed to working in partnership with patients. All of the patients we spoke with and received comments from, during our inspection made positive comments about the practice and the service they provided. They were particularly complimentary about the genuine caring and helpful attitude of both the clinical and non-clinical staff and the sound clinical care. We heard examples from patients about how the doctors had gone the extra mile to ensure they received appropriate care and treatment. We heard two examples of when a patient had been discharged from hospital without appropriate support and the GP had acted immediately to ensure the patient received the support they needed. Patients also told us that they were involved in decisions about their care and treatment, were listened to and were treated with dignity and respect.

We saw that patient's confidentiality was respected when care was being delivered and during discussions that staff were having with patients. Facilities were available for patients to talk confidentially to clinical and non-clinical staff members.

During our inspection we overheard and observed positive interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. The patients we spoke with and the comments cards we received confirmed that staff were friendly and caring in their approach.

We reviewed the annual patient survey dated December 2013, to which 254 patients had responded. The results showed the practice had received an 88% satisfaction rate for services provided and 40% of these were rated as excellent.

Information was available for patients for bereavement support and the GPs sent a bereavement card to relatives on behalf of the staff. A record of patients who had recently died was in place to ensure that inappropriate correspondence was not sent.

Involvement in decisions and consent

Staff involved patients in decisions about their care and treatment. The clinical staff we spoke with told us that they provided information to support patients to make decisions about their care and treatment. This included giving patients the time they needed to ensure they understood the care and treatment they required. The patients we spoke with and the comments cards we received confirmed this and patients told us that their views were listened to.

We saw the practice's consent policy and its guide to the Mental Capacity Act (MCA) (2005). These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. All staff were aware of patients who needed support from nominated carers and clinicians ensured that carers' views were listened to as appropriate.

The practice had access to a telephone translation service to assist patients if required.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs.

The practice had identified the need for and trained a health care assistant so they could provide a range of services for patients. The practice provided their own phlebotomy service, electrocardiograms (ECGs) and 24 hour ECGs (an ECG records the electrical activity of the heart), spirometry (a test that can help diagnose various lung conditions, and is used to monitor the severity of some lung conditions, and their response to treatment).

They also provided a GP service for patients admitted to nine intermediate care beds which had facilities, including physiotherapy, occupational therapy and nursing. There was a focus on enablement, which was led by one of the GPs, and palliative care, led by another GP. We saw evidence of positive impact, which included for example, a reduced length of stay in an acute hospital, admission avoidance and increased patient satisfaction for patients, including patients at the end of their life, and their carers, as care was provided closer to home. The practice provided a service to patients from other areas where their usual practice refused to visit them as they were out of the area. Patients using the intermediate care beds were temporarily registered with the practice.

An Improving Access to Psychological Therapy (IAPT) service was provided on a weekly basis. This was also available to non-registered patients. The practice were aware of how to access mental health crisis support services and make referrals to this service appropriately.

Patients could request to have permanent online access to their medical records, from the date of this being requested. Whilst this is going to be a requirement for all practices in the future, this was already available at this practice.

Access to the service

The practice was situated in a ground level building, which had been adapted to accommodate a dispensary and additional clinical rooms. There were automatic doors to assist patients with mobility needs or with children in pushchairs, to gain easy access. We received positive feedback from patients about the premises being accessible.

Appointments at the practice could be made online, by telephone or in person. Patients were able to choose whether they saw a male or female GP. All the patients told us they were able to obtain a routine or urgent appointment when they needed to. There was a range of pre bookable, on the day and telephone consultation appointments available every weekday. Each GP also had one urgent appointment available at 5pm every day. Patients who worked and were not able to attend during the practice opening hours were booked in after the surgery was closed. School age children were able to make appointments outside of school hours. Home visits were undertaken and shared between the GPs working that day. Two patients told us there can be a long wait in the waiting room, whilst waiting for a booked appointment, but they did not mind because the doctors provided a thorough consultation.

There was a longer wait to get an appointment with a nurse and we spoke with the practice about this. They advised that they undertook monthly audits on the appointments and there was a higher 'did not attend' (DNA) rate with the nurse appointments, which they felt may be due to the appointments being booked so far in advance. The nurse hours were being increased from September 2014, in response to the health care assistant being on maternity leave.

The out of hours service could be accessed by phoning the practice which automatically re-directed the call. Out of hours information was also available on the noticeboard in the practice.

Patients could order repeat prescriptions by post, online or in person at the practice. The practice aimed to have the prescription ready for collection within 48 hours. Patients could also have their prescription form posted to their home or to Boots pharmacy in March.

Meeting people's needs

We saw that patient correspondence and laboratory results were reviewed by a GP in a timely way and actioned appropriately. There was evidence that timely referrals were made. Some of the patients we spoke with and received comments cards from, gave examples of when the

Are services responsive to people's needs?

(for example, to feedback?)

doctors had gone the extra mile to ensure they received appropriate treatment and follow up from other services. For example one patient shared how the GP had 'fought' to get them the correct secondary care treatment.

Concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice and these were discussed at the weekly partners and practice manager meeting and in the monthly practice meeting, as appropriate.

There was a complaints procedure which patients were informed of by a notice in the waiting area, on the practice website and in the practice leaflet. Some of the staff we spoke with were not aware of the complaints policy and told us they would direct any complaints to the practice manager. All of the patients we spoke with told us they were aware of how to complain or how to find out how to complain. Patients we spoke with had not had any cause to complain but they believed that any complaint would be taken seriously.

We were unable to review the complaints records as there had not been any written complaints. We looked at the complaints policy and spoke with the practice manager to ask how complaints would be dealt with by the practice. There was a process in place for these to be acknowledged, investigated and responded to and for learning to be shared.

Are services well-led?

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

Our findings

Leadership and culture

The senior partner told us that the ethos of the practice was to provide an 'old fashioned personalised service using the best evidence.' Although this was not documented, it was evident during our inspection.

Governance arrangements

There were clearly identified areas of lead responsibility for areas such as information governance, infection control, child safeguarding and adult safeguarding and complaints**.** The responsibilities were shared between the doctors, a nurse and the practice manager. There was evidence of these roles being effective in practice, as staff we spoke with knew who had lead responsibility in the practice. Although, it was clear that staff could go to any of the doctors for advice regarding any of these roles.

Systems to monitor and improve quality and improvement (leadership)

The practice had a system to assess and monitor the quality of service that patients received. There was a weekly partners and practice manager meeting, which included discussion of quality issues. There was a commitment to learn from incidents and there was an open approach to these issues. Staff were informed of any learning directly and also through monthly clinical governance meetings which all staff attended.

The practice participated in external peer review, for example the prescribing lead attended the local commissioning group prescribing meetings.

Patient experience and involvement

The practice used an independent company to carry out an annual survey of its patients. One of the benefits of this was that it enabled the practice to compare its performance with the national average for practices of a similar size. 254 patients responded to the most recent survey in December 2013. The results showed that the practice achieved 88% on the satisfaction of services provided and 40% of those were rated as excellent. The two areas where the practice scored lower were telephone access and satisfaction with opening hours.

The practice had a patient participation group (PPG). A PPG is made up of practice staff and patients that are representative of the practice population. The main aim of the PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

We saw that the PPG and the practice had reviewed the results of the patient survey in December 2013 and had developed an action plan to address the areas where the practice scored lower. We saw evidence that some of the actions had been completed. The practice would like to increase the appointments by recruiting another GP, however consultancy room space was limited making this difficult to implement.

The PPG representatives we spoke with told us that they felt able to express their views to the practice and that any suggestions they had for improving the service were taken seriously. We were told that the PPG had raised funding for practice equipment which had been used to provide a range of different seating in the waiting room and audiology equipment.

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

The practice manager was based centrally in the practice building and told us this was so that they were accessible for staff and they were aware of what was occurring in the reception and waiting area, should they need to respond.

Patients were encouraged to feedback their views. Information was provided on the practice website and in the practice leaflet to put comments in writing to the practice manager. There was a suggestions box in the waiting area, although the practice manager advised that they rarely received feedback in this way.

All the staff we spoke with said they felt supported and listened to by the partners and practice manager. Staff were aware of how to raise suggestions and concerns and all of the staff we spoke with said that they would feel confident to do this and would be listened to.

Management lead through learning and improvement

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

Are services well-led?

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

We saw that staff were supported to develop their knowledge and skills and the practice supported staff to gain additional qualifications, for example, a dispensing qualification.

There was a monthly clinical governance meeting, which all the staff attended. We looked at the minutes of these minutes and saw that they covered significant events, infection control, health and safety, fire safety and training. Time was available during the clinical governance meeting for learning to be undertaken and shared.

Identification and management of risk

There was no formal register of corporate risks at the practice but we saw evidence that some risks had been identified and action taken to minimise their potential impact. For instance there was an approved quote to make improvements to the existing car park.

Older people

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

Our findings

One of the GPs led a multidisciplinary meeting each week for patients who were in the intermediate care beds. Some of the patients in the intermediate care beds were aged 75 and over. This was followed by a weekly surgery for patients who lived at Doddington Court, which was a sheltered accommodation facility. The GPs met every two weeks with other members of the multidisciplinary team to review patients at the end of their life, patients with complex needs and to review and minimise unplanned admissions.

The dispensary staff told us that they take dispensed items to patients in the waiting area rather than call them to the reception area to reduce the time they spend standing at the dispensary. There was a daily delivery of repeat medicines to patients who lived at Doddington Court (sheltered accommodation) who self-medicate, in order for them to maintain their independence.

Patients who were over 75 had a named GP, who was responsible for the overview of their care. The allocation of named GPs was decided by discussion with the GPs at a partnership meeting. Patients were informed by letter and three patients had requested they changed their named GP, which was accepted by the practice.

People with long term conditions

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

Our findings

The practice held clinics to support patients with a range of long term conditions, including asthma, cardio vascular disease and diabetes. There was an effective follow up procedure in place for patients who did not attend for their review. This included written and telephone contact and if the patient still did not attend this was noted on the patient's record for the GP to discuss with them when they next visited.

Patients with long term conditions who lived in a care home were regularly reviewed and this review was undertaken in the care home itself.

People with long term conditions who had frequent unplanned attendance to hospital were reviewed. Some patients were issued a 'rescue pack' which included inhalers if these were needed in order to reduce their unplanned attendance to hospital.

A Diabetes Consultant reviewed patients who found it difficult to follow advice during quarterly visits to the practice.

Mothers, babies, children and young people

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

Our findings

Health screening and health promotion literature was available for this group. Chlamydia screening information was displayed in the toilet area.

There was a widespread uptake of childhood immunisations and flu vaccination.

Antenatal care was provided by the Hinchingbrook midwives, and baby clinics were held in Chatteris. The GPs undertook a postnatal check for the mother and the baby, six weeks after the birth of the baby.

New patient checks for looked after children (those children and young people who are looked after by the state/local authority) were undertaken by the GP.

School age children were able to make appointments outside of school hours.

Working age people (and those recently retired)

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

Our findings

Although the practice did not offer extended hours appointments, we were told that the practice would accommodate patients who were unable to attend during usual practice opening hours. Patients could consult the doctors by telephone rather than visiting the surgery.

Patients were offered a choice when they were referred to other services.

The practice delivered dispensed medicines to patients who self-medicated who lived nearby at Doddington Court, a nearby sheltered housing facility.

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

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

Our findings

There were no barriers to accessing the services at the practice for any vulnerable group. The staff believed that patients could access the practice's services without fear of stigma and prejudice.

The dispensary staff told us that they supported vulnerable patients when they requested repeat prescriptions, to ensure they requested the correct medicines.

The practice had identified patients with learning disabilities, although there was no evidence that annual health checks had been completed or offered.

People experiencing poor mental health

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

Our findings

Doctors had the necessary skills and information to treat or refer patients with poor mental health. Data from the QOF showed that the practice achieved higher than 60% of the other practices in the CCG for completing a physical health check for patients with severe mental impairment within the previous 15 months.

An Improving Access to Psychological Therapy (IAPT) service was provided on a weekly basis. This was also available to non-registered patients. The practice was aware of how to access mental health crisis support services and made referrals appropriately.

The dispensary staff managed weekly dispensing of some medicines for people who received treatment from the drug and alcohol service.