Sawston Medical Practice

Quality Report

Sawston Medical Practice
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Good ●
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Sawston Medical Practice on the 10 June 2015 and carried out a comprehensive inspection. The overall rating for this practice is outstanding. We found that the practice provided a safe and caring service. They were outstanding in the relation to their effectiveness, responsiveness and in being well led.

We examined patient care across the following population groups: older people; those with long term medical conditions; families, 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, including those with dementia. We found that care was tailored appropriately to the individual circumstances and needs of the patients in these groups. The population groups were rated good, with older people and those with long term conditions rated as outstanding.

Our key findings were as follows:

- Feedback from all the patients we spoke with and received comments cards from was positive. Patients told us they were treated with dignity, care and respect. They were involved in decisions about their care and treatment and were highly complimentary about the care that they received from the practice.
- The practice addressed patients' needs and worked in partnership with other health and social care services to deliver individualised care to patients.
- The needs of the practice population were understood and services were offered to meet these. The practice offered a rapid access clinic for patients to be seen urgently. This included a visiting GP, who was available from 8:00am to 6:00pm to undertake home visits. Patients were satisfied with the appointment system.
- Feedback from representatives from care homes where patients were registered with the practice was very positive in all areas.
- There was a clear leadership structure with delegated authority for decision making. All the staff we spoke with told us they felt very well supported by their peers and by the managers.

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- The practice proactively sought feedback from staff and patients. There were numerous examples of how the practice had positively responded to these. These included a weekly staff newsletter, redesigning the practice website and talking to community groups about the most effective way of them accessing health services.
- The practice operated from a purpose built building and had a dedicated emergency treatment room and a separate room for treating patients with methicillin-resistant staphylococcus aureus (MRSA). MRSA is a type of bacteria that's resistant to a number of widely used antibiotics.

However, there were also areas of practice where the provider needs to make improvements. The provider should:

- Improve the arrangements for the security of blank prescription forms.

We saw a number of areas of outstanding practice:

- The practice offered a rapid access clinic for patients to be seen urgently. This included a visiting GP, who was available from 8:00am to 6:00pm to undertake home visits. The practice published monthly performance data for appointments, consultations and waiting times. The practice had low average waiting times, for March 2015 this was 4.7 minutes.
- Patients with long term conditions were recalled at least annually for an appointment to have all relevant tests undertaken. The results were then reviewed by one GP who advised on the most appropriate action for the patient. If patients did not require further intervention, this was not provided. This reduced the need for patients to attend numerous appointments, promoted self care and ensured their care and treatment needs were managed holistically.
- The practice delivered medicines to some villages, where there were central collection points. Staff also delivered medicines to some patients who were housebound and were extending this to patients who had difficulty in collecting their medicines. Staff who delivered these medicines had undertaken a Disclosure and Barring Service check to help ensure their suitability for undertaking this role.
- The practice ran a walking group every Tuesday which was available for patients to help them maintain their health and well-being.
- The practice provided an ear micro suction service for its own patients and also non-registered patients. This was requested by the Clinical Commissioning Group due to a lack of provision in the area. This reduced the need for patients to travel to hospital clinics.
- Health passports, which had been developed by the practice, were given to all patients with long term conditions and to all new patients who registered at the practice. This enabled them to keep a record of their health status, to set their own health goals and monitor their progress towards their goals. Patients could also seek support from the practice to do this. The passport had simple text and illustrations which helped make it simple to follow.
- Staff received a weekly newsletter which updated them with important information and included the positive achievements of staff.
- A staff survey was undertaken annually and the practice's response included both improvements to work processes, including staff training and also social events.
- A breastfeeding room and a separate baby changing room were available for patients to use.
- The practice worked closely with The John Huntingdon Trust. This is a charity that works in conjunction with the Citizens Advice Bureau. The practice made referrals to The John Huntingdon Trust so that patients, particularly those who were vulnerable, were able to receive support for issues that were not medical in nature.

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. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. When things went wrong these were investigated to help minimise reoccurrences. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed.

Risks to patients were assessed and well managed. Patients, including children, who were identified as being at risk were monitored and the practice worked with other agencies as appropriate to safeguard vulnerable adults and children. There were enough staff employed to keep patients safe. Premises were clean and risks of infection were assessed and managed. The practice had suitable equipment to diagnose and treat patients and medicines were stored and handled safely.

Are services effective?

Outstanding

The practice is rated as outstanding for effective. Data showed patient outcomes were above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of patients' mental capacity and the promotion of good health. Health passports, which had been developed by the practice, were given to all patients with long term conditions and to all new patients who registered at the practice. This enabled them to keep a record of their health status, to set their own health goals and monitor their progress towards their goals. Patients could also seek support from the practice to do this. The passport had simple text and illustrations which helped make it simple to follow. We saw evidence of effective multidisciplinary working. The practice had an induction programme in place for new staff. Staff had received training appropriate to their roles and further training needs had been identified and planned for. Staff had received an annual appraisal of their performance.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice in line with or slightly higher than others in the locality for several aspects of care. All the patients we spoke with and received comments cards from told us they were treated with compassion, dignity and respect. They were listened to by all staff

Summary of findings

and involved in care and treatment decisions. Feedback from patients was extremely complimentary. Information was provided to help patients understand the care available to them, although this could have been more easily available. We also observed that staff treated patients with kindness and respect and ensured that confidential information about them was maintained.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for responsive. The practice reviewed and addressed the needs of their local population. This included rapid access appointments for those with enhanced needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As home visits could be undertaken from 8:00am, this provided more time during the day to engage appropriate care and support according to the patients' needs. Patients reported high levels of satisfaction with the appointments system. They had access to telephone consultations, early morning and late evening appointments and urgent appointments available the same day. The practice was well equipped to treat patients and meet their needs. Staff proactively sought the views of patients and responded according to patient feedback in order to improve the service. There was a separate baby changing room and a separate baby feeding room. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised and there was evidence of learning as a result of complaints that had been made.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for well-led. There was a practice charter, which outlined how staff would treat patients and how patients were asked to treat staff. The practice had a vision and staff were aware of their responsibilities in relation to this. Staff were clear of their roles and areas of responsibility and were empowered to make decisions independently. There was a clear managerial and clinical leadership structure for support, if this was needed. There was delegated responsibility for decision making by the executive team. This enabled risk to be escalated promptly if needed and action taken following decision by the executive team.

The practice had a number of policies and procedures to govern its activity. These were all in date and a date identified for their review. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and staff, which included an annual staff survey. There were numerous examples of where feedback from patients and staff had

been acted upon. A staff newsletter was written weekly which celebrated achievements by practice staff and provided an update on actions from meetings and important information. Staff had attended internal and external clinical and peer support meetings and had received an annual appraisal. All the staff we spoke with reported that they had appropriate training, opportunities to gain additional qualifications and felt very well supported in their work.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. Nationally reported data showed the practice had above average outcomes compared with the Clinical Commissioning Group and England for conditions commonly found amongst older people. Patients over the age of 75 had a named GP who was responsible for the coordination of their care. The practice offered proactive, personalised care to meet the needs of the older people in its population.

The practice was responsive to the needs of older people. This included rapid access appointments for those with urgent needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As the visiting GP did home visits from 8:00am, this gave them more time to engage appropriate care and support during the day, according to the patients' needs. Patients who were housebound could have their medicines delivered to their home by a member of the dispensing team at the practice.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the population group of people with long term conditions. Nationally reported data showed the practice had above average outcomes compared with the Clinical Commissioning Group and England for patients with long term conditions. Patients with long term conditions were recalled at least annually for an appointment to have all relevant tests undertaken. The results were then reviewed by one GP who advised on the most appropriate action for the patient. If patients were identified as needing to be seen at the practice's long term medical condition clinics, this was arranged. GPs, advanced nurse practitioners and practice nurses specialised in a number of long term conditions and held these clinics. This reduced the need for patients to attend numerous appointments and ensured their care and treatment needs were managed holistically and efficiently. Health passports, which had been developed by the practice, were given to all patients with long term conditions. This enabled them to

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keep a record of their health status, to set their own health goals and monitor their progress towards their goals. Patients could also seek support from the practice to do this. The passport had simple text and illustrations which helped make it simple to follow.

The practice was responsive to the needs of people with long term conditions. This included rapid access appointments for those with urgent needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As the visiting GP did home visits from 8:00am, this gave them more time to engage appropriate care and support during the day, according to the patients' needs.

Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed, longer appointments and home visits were available. For those people with the most complex needs the GPs and nurses worked with relevant health care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. A breastfeeding room and a separate baby changing room were available for patients to use. A midwife led clinic was available for patients on a weekly basis for booked appointments and there was also a weekly drop in clinic. A recall system was in place for the mother and baby six week check. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

The practice was responsive to the needs of families, children and young people. This included rapid access appointments for those with urgent needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As the visiting GP did home visits from 8:00am, this gave them more time to engage appropriate care and support during the day, according to the patients' needs.

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The practice had a lead GP for children and child safeguarding. The practice had higher percentages of children who had received vaccination when compared with the Clinical Commissioning Group. There was evidence of close working with the health visitors and school nurses. A vulnerable children meeting was held regularly where vulnerable children under five years of age were reviewed and those on the child protection register.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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. Early morning appointments were available from 7.00am to 8.00am on a Friday and on Monday evenings from 6.00pm to 8.00pm. The practice offered same day telephone consultations where the patient believed they needed urgent medical advice. If patients were currently receiving care and treatment, they could request a telephone consultation and if this was urgent it would be the same day. If it was not urgent this would be within 72 hours and by the current treating GP, for continuity. Patients were able to advise when the best times for the GP to call would be.

The practice was responsive to the needs of working age people (including those recently retired and students). This included rapid access appointments for those with urgent needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As the visiting GP did home visits from 8:00am, this gave them more time to engage appropriate care and support during the day, according to the patients' needs.

A full range of health promotion and screening which reflected the needs for this age group was also available.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. Nationally reported data showed the practice performed above the Clinical Commissioning Group (CCG) and England average for people with a learning disability. The practice held a register of patients with a learning disability and 98% had received an annual health check in

the previous year. There was a process for following up vulnerable patients who did not attend for their appointment. We were told that longer appointments were given to patients who needed more time to communicate during a consultation, for example patients who needed an interpreter. There were arrangements for supporting patients whose first language was not English.

The practice was responsive to the needs of patients whose circumstances might make them vulnerable. This included rapid access appointments for those with urgent needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As the visiting GP did home visits from 8:00am, this gave them more time to engage appropriate care and support during the day, according to the patients' needs.

The practice worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. They worked with The John Huntingdon Trust in order for vulnerable patients to receive support for issues that were not medical in nature. This is a charity which provides advice support, housing and grants to people living in Sawston. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

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 dementia). Nationally reported data showed the practice scored above the Clinical Commissioning Group (CCG) and England average for people with mental health needs and for those with dementia. The practice kept a register of all patients with dementia. We were told that 72 of the 91 patients (79%) with dementia, who were eligible for a health check had attended for one. There was also a process in place for following up those patients who did not attend for their appointment.

The practice was responsive to the needs of people experiencing poor mental health, including those with dementia. This included rapid access appointments for those with urgent needs and a visiting GP who was available for home visits from 8:00am to 6:00pm. The visiting GP assessed and prioritised requests for home

visits based on clinical need and gave patients an indication of the time they were likely to be visited. This ensured that patients who most needed to receive intervention from a GP received it. As the visiting GP did home visits from 8:00am, this gave them more time to engage appropriate care and support during the day, according to the patients' needs.

One of the GPs was the lead for mental health and worked closely with the GP lead for children where this was appropriate, in order to effectively support families where patients had mental health needs. The GP lead worked closely with a Consultant Psychiatrist and with their agreement started patients on medications to prevent them needing to be admitted into secondary care. This involved close monitoring of patients by the GP and patients having easy access to this lead GP. This included supporting patients with personality disorders, complex depression and addiction.

The practice worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. Patients were referred to other mental health services as appropriate. There was a proactive approach to following up patients with mental health needs who had cancelled their appointment.

Summary of findings

What people who use the service say

We spoke with four patients during our inspection. All of the patients told us they felt listened to and supported by staff. They also had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that the clinicians were caring, took their concerns seriously and spent time explaining information in relation to their health and treatment to them in a way that they could understand. Patients were satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. Patients were very complimentary on the support they received to manage their long term conditions and commented positively on the knowledge of the nurses. They also reported a good experience with getting repeat prescriptions for their medicines.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 22 Care Quality Commission comment cards. All of the comments on the cards were positive about the practice. A number of comments singled out specific clinicians for their expert advice and excellent service. There were positive comments about the ability to get an urgent appointment quickly and not having to wait too long after their booked appointment time. Patients reported that they were given thorough explanations of their treatment and their health needs were followed up appropriately.

We spoke with representatives from two care homes where patients were registered with the practice. They were very complimentary about the service provided by the GPs and the speed of attendance in response to home visit requests. They reported that patients were treated with dignity and respect. We were told that patient consent was obtained when this was needed and that they involved staff and relatives appropriately in care and treatment decisions. Representatives we spoke with told us that the staff were well informed of the needs of the patients. We were told that patients' medicines were reviewed regularly and this was undertaken by one of the GPs. One representative told us there could occasionally be a delay in obtaining prescriptions. Patients with long term conditions were also monitored and reviewed regularly. We were advised that referrals had been made in a timely way and representatives knew how to complain if they needed to.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for the security of blank prescription forms.

Outstanding practice

- The practice offered a rapid access clinic for patients to be seen urgently. This included a visiting GP, who was available from 8:00am to 6:00pm to undertake home visits. The practice published monthly performance data for appointments, consultations and waiting times. The practice had low average waiting times, for March 2015 this was 4.7 minutes.
- Patients with long term conditions were recalled at least annually for an appointment to have all relevant tests undertaken. The results were then reviewed by one GP who advised on the most appropriate action for the patient. If patients did not require further intervention, this was not provided. This reduced the need for patients to attend numerous appointments, promoted self care and ensured their care and treatment needs were managed holistically.
- The practice delivered medicines to some villages, where there were central collection points. Staff also

delivered medicines to some patients who were housebound and were extending this to patients who had difficulty in collecting their medicines. Staff who delivered these medicines had undertaken a Disclosure and Barring Service check to help ensure their suitability for undertaking this role.

- The practice ran a walking group every Tuesday which was available for patients to help them maintain their health and well-being.
- The practice provided an ear micro suction service for its own patients and also non-registered patients. This was requested by the Clinical Commissioning Group due to a lack of provision in the area. This reduced the need for patients to travel to hospital clinics.
- Health passports, which had been developed by the practice, were given to all patients with long term conditions and to all new patients who registered at the practice. This enabled them to keep a record of their health status, to set their own health goals and monitor their progress towards their goals. Patients could also seek support from the practice to do this. The passport had simple text and illustrations which helped make it simple to follow.
- Staff received a weekly newsletter which updated them with important information and included the positive achievements of staff.
- A staff survey was undertaken annually and the practice's response included both improvements to work processes, including staff training and also social events.
- A breastfeeding room and a separate baby changing room were available for patients to use.
- The practice worked closely with The John Huntingdon Trust. This is a charity that works in conjunction with the Citizens Advice Bureau. The practice made referrals to The John Huntingdon Trust so that patients, particularly those who were vulnerable, were able to receive support for issues that were not medical in nature.

Sawston Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP Specialist Advisor. The team also included a nurse specialist advisor, a medicines management inspector and another CQC inspector.

Background to Sawston Medical Practice

Sawston Medical Practice, in the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area, provides a range of general medical services to approximately 14000 registered patients living in Sawston, Duxford, Whittlesford, Pampisford, Hinxton and other surrounding villages.

According to Public Health England information, the patient population has an average number of patients aged 0-4, and slightly lower than average number aged between 5-14 and aged 15 to 18 compared to the practice average across England. It has a slightly higher number of patients aged 65 to 84 and an average number of patients aged over 85 compared to the practice average across England. Income deprivation affecting children and older people is significantly lower than the practice average across England.

There are six GP partners, three male and three female who hold financial and managerial responsibility for the practice. There are also salaried GPs, nurses (including advanced nurse practitioners and practice nurses, health care assistants and a phlebotomist. There are also receptionists, administration staff, cleaning staff and a practice business manager. There is a dispensary at the practice, led by a superintendent pharmacist with a number of dispensing staff. The practice is a teaching practice for medical students and qualified doctors who are training to be GPs. It is approved by Cambridge University.

The practice provides a range of clinics and services, which are detailed in this report. It operates between the hours of 8.00am and 6.00pm, Monday to Friday with additional hours from 6.00pm to 8.00pm on a Monday and 7.00am to 8.00am on a Friday. Outside of practice opening hours a service is provided by another health care provider, Urgent Care Cambridgeshire.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

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.

Detailed findings

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and other information that was available in the public domain. We also reviewed information we had received from the service and asked other organisations to share what they knew about the service. We talked to the local clinical commissioning group (CCG), the NHS local area team and Healthwatch. The information they provided was used to inform the planning of the inspection.

We carried out an announced inspection visit on 10 June 2015. During our visit we spoke with a range of staff, including five GPs, three nurses, five administration staff, two reception staff, dispensing staff, the cleaning supervisor, facilities manager and the practice business manager. We spoke with two members of the patient participation group (PPG). This is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We also spoke with four patients who used the practice. We reviewed 22 comments cards where patients had shared their views and experiences of the practice. We spoke with representatives from two residential homes where patients were registered with the practice.

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?

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

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. There were records of complaints in paper copy prior to 2007 and electronic copy from 2007. There were records of significant events that had occurred from 2008. We looked at the records of complaints and significant events since January 2014 and we were able to review these. For example one significant event related to an incident where it was identified that monitoring equipment was out of date. An audit of this equipment was undertaken. This resulted in the equipment now being kept in known locations and nurses monitor for expiry dates. A revision was also made to the room stocking procedure. We noted that an annual review of complaints had occurred to ensure that learning from them had taken place and to prevent their reoccurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including dispensary, receptionists and clinical staff were aware of the system for raising significant events and felt encouraged to do so. Patient safety issues and complaints was a standing item on the weekly executive meeting, the weekly clinical meeting agenda and the bi weekly heads of department meeting. We saw evidence that significant events and complaints were discussed and actions from past significant events and complaints were reviewed.

We looked at the records of significant events and saw these had been completed in a comprehensive and timely manner. We looked at a number of significant event analyses and saw evidence of action taken as a result. One significant event resulted in a change to practice where patients with known mental health needs cancelled an appointment. The responsible clinician was now informed when this happened, in order for them to judge what action might be needed. Staff told us that if they were involved in a significant event they would receive feedback directly and also through meetings. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff via a number of meetings.

National patient safety alerts were reviewed by the pharmacist if they related to medicines. Other safety alerts were reviewed by the executive team. A decision was made on the action to be taken and who was best placed to do this. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. For example one alert related to the use of a medication to relieve feelings of sickness or vomiting which might be harmful to the heart. We were told that all patients on a repeat prescription were reviewed and their treatment stopped or changed appropriately. Staff also told us alerts were discussed at the clinical meetings to ensure all staff were aware of any that were relevant to the practice.

Reliable safety systems and processes including safeguarding

The practice had a range of documentation to advise staff of their role and responsibility in relation to safeguarding children and vulnerable adults. This included safeguarding vulnerable adults and safeguarding children's policies and contact information for safeguarding professionals external to the practice. We asked members of medical, nursing and administrative staff about their safeguarding knowledge. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

The practice had appointed a dedicated GP as the lead in safeguarding children and another lead for safeguarding vulnerable adults. They had been trained to level three, as had the other GP partners. We spoke with one of the safeguarding leads who could demonstrate they had the necessary training and competence to enable them to fulfil this role. All the staff we spoke with were aware who these leads for safeguarding were and who to speak with in the practice if they had a safeguarding concern.

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a

system to highlight vulnerable patients on the practice's electronic records. There was a process in place for following up patients who did not attend or cancelled their appointment, as appropriate.

There was a chaperone policy and patients we spoke with were aware they could request a chaperone. 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). There were notices informing patients that this service was available. However we noted that these were not placed where they could be clearly seen by patients. Information about the chaperone policy was available on the practice's website. Staff told us that clinical staff acted as chaperones and had a Disclosure and Barring Service check to help ensure their suitability to work with vulnerable people. Disclosure and Barring Service (DBS) checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. Staff we spoke with understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

We noted that the practice delivered medicines to some people who were housebound. The Human Resources administration lead told us that staff who undertook this role had undergone a disclosure and barring service check.

Medicines management

We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. We noted the dispensary itself was well organised and operated with adequate staffing levels.

The superintendent pharmacist told us that members of staff involved in the dispensing process were appropriately qualified and their competence was checked each year. We looked at staff training files for five dispensary staff, we found they all contained evidence of relevant training but not all had evidence that an annual assessment of competence was completed. However, we were satisfied that medicines were dispensed by appropriately qualified and competent staff.

There were arrangements in place for the security of the dispensary so that it was only accessible to authorised staff. The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. We looked at the annual return of performance against the DSQS standards and were assured that dispensing performance was of a high standard. We saw evidence that the practice monitor and record dispensing errors or near misses and that regular audits of prescribing and dispensing arrangements were carried out. We were assured that there was a culture of learning from medicine related incidents.

A policy and procedure folder was available in the dispensary for staff to refer to about standard operating practices. We saw that procedures were updated regularly, and records showed that staff had read the procedures relevant to their work.

Patients were offered a choice of methods for requesting repeat prescriptions. We saw that this process was handled well by dispensary staff to ensure patients were not kept waiting unduly for their medicines. A medicines delivery service was available for patients in rural settings who may have difficulty accessing the surgery for their medicines.

We found that there were arrangements for the secure storage of blank prescription forms. However the security and record-keeping practices were not in line with national guidance and we could not be assured that if prescriptions were lost or stolen this could be promptly identified and investigated.

Processes were in place to check medicines in the practice were within their expiry date and suitable for use. Separate packs, which included medicines that may be required, were available for GPs to take on home visits. GP home visit packs and medicines for use in an emergency in the practice were monitored for expiry and checked regularly for their availability. Records demonstrated that vaccines and medicines requiring refrigeration had been stored within the correct temperature range. Guidance was available to staff which explained what to do in the event of refrigerator temperatures being outside of the accepted range. Staff described appropriate arrangements for maintaining the cold-chain for vaccines following their delivery.

Cleanliness and infection control

We observed the premises to be clean and tidy. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

Good

Are services safe?

The practice employed their own cleaner. We saw there were cleaning schedules in place, which included daily, weekly and monthly cleaning tasks and cleaning records were kept. Some cleaning responsibilities were undertaken by clinical staff, for example cleaning of medical equipment and couches in between patients. We saw that records of this cleaning were kept. Spillages and samples were dealt with by clinical staff only and there was guidance in relation to this. We saw evidence of this during the inspection. We were told by the infection control lead nurse that regular checks of the quality of the cleaning were undertaken and we saw records of this. We noted that where issues with the cleaning had been identified, these had been dealt with and improvements were noted during the next check.

The practice had a lead nurse for infection control who had undertaken training to enable them to provide advice to the practice on infection control. We saw evidence that the infection control lead had carried out an infection control audit in November 2014. We saw evidence that actions had been identified following the audit and these had been completed. For example pedal operated bins in clinical areas and training regarding the correct labelling and safe use of sharps bins. We noted that arrangements for dealing with clinical waste were appropriate and we noted that sharps bins had been labelled correctly.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap, hand gel and paper hand towel dispensers were available in treatment rooms.

The practice had a completed risk assessment for legionella, which was dated April 2013. Legionella is a term for particular bacteria which can contaminate water systems in buildings. We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had 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 on a two yearly basis, as it had been assessed as low risk by the practice. A schedule of testing was in place and we noted this had last been completed in September 2013. We saw evidence of calibration of relevant equipment; for example baby weighing scales, automated external defibrillator and ear syringes.

Staffing and recruitment

The practice had a recruitment policy and procedure that set out the standards it followed when recruiting clinical and non-clinical staff. This did not include the practices requirements for Disclosure and Barring Service (DBS) checks or checking that clinicians were registered with the appropriate professional body. Disclosure and Barring Service (DBS) checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable. We spoke with the practice business manager about this and they told us that these checks were included and recorded as part of the induction checklist. They told us that all clinical staff, including two pharmacists and any member of staff who was likely to deal with patients on a one to one, face to face basis at the practice or who drove to visit patients in their own homes also had a DBS check. Following the inspection we were provided with the practice's protocol for disclosure and barring service. We were also sent confirmation that DBS checks were in place for the identified staff.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken for staff prior to their employment. For example, proof of identification, references and qualifications. We saw that regular checks were undertaken to ensure that clinical staff had up to date registration with the appropriate professional body. The professional registration number of each of the GPs and nurses was provided on the door to their consulting room.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff

were on duty. Staff told us there were enough staff to maintain the smooth running of the practice and there were enough staff on duty to keep patients safe. There was an arrangement in place for members of staff to cover each other's annual leave. We were told that any risks were escalated to the executive team, for action to be agreed to reduce or eliminate the risk. For example, during periods of leave when there may not be sufficient staff available at specific times. We were advised that when this had been identified, the GPs worked additional sessions in order to ensure sufficient cover at the practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies, equipment, health and safety and fire risk assessments. The practice also had a health and safety policy and there was an identified health and safety lead.

The practice had a dedicated facilities manager. There was a planned maintenance schedule which included for example, fire equipment checks, legionella checks and gas boiler checks. We saw that any risks, including risks to patients, significant events, complaints or infection control were escalated for discussion at the weekly executive meeting.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told by the human resources administration lead, that all clinical staff had undertaken basic life support training. They were aware of the non-clinical staff who were due to receive this training. They told us that this was being delivered internally by one of the nursing staff. Emergency equipment was available including access to oxygen and an automated external defibrillator. This is a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm. Oxygen is widely used in emergency medicine, both in hospital and by emergency medical services or those giving advanced first aid. Having immediate access to functioning emergency oxygen cylinder kit helps people survive medical emergencies such as a heart attack. Staff we spoke with all knew the location of this equipment and records confirmed that it was checked weekly.

Emergency medicines were available in a secure area of the practice and included those for the treatment of cardiac arrest, anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar). Staff we spoke with knew of their location. Processes were also in place to check whether emergency medicines were available and within their expiry date and suitable for use. All the emergency medicines we checked were in date and fit for use.

A disaster recovery and business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. This was reviewed annually and had last been reviewed in January 2015. Risks identified included for example, loss of electricity supply, loss of telephone system, loss of connection to the clinical system and internal flooding. The document also contained relevant contact details for staff to refer to. The practice business manager confirmed that copies were kept off site.

The practice had a fire safety policy and had carried out a fire risk assessment that included actions required to maintain fire safety. The fire risk assessment was dated 29 November 2014. We noted that areas for action identified in the fire risk assessment had been completed. For example evacuation chairs were now installed upstairs and training had been undertaken in their use. We saw records of checks of the emergency lighting, which was undertaken monthly and of the fire alarm, which was undertaken weekly. There was a certificate of maintenance of fire equipment which was dated 25 June 2014. We were told by the facilities manager that a fire drill had been undertaken, although this had not been documented. They told us that they had identified areas for learning following this and that the identified fire marshals for the practice had been informed of this change to practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice worked externally with a number of local and national organisations. The practice business manager was an executive on the local clinical commissioning group. One GP partner was on the local medical committee board. We were told their involvement in these meetings enabled the practice to respond quickly to what was happening nationally and influence what was and needed to be commissioned locally.

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. These were shared at the clinical meetings. The staff we spoke with confirmed that patients 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 best practice and these were reviewed when appropriate.

The GPs at the practice had developed their own in-house specialisms such as mental health, medicines management, minor surgery and paediatrics, many of which were of benefit to the wider community as well as the patients registered at the practice. Many of the GPs had linked with external organisations where they had fostered a reciprocal approach to sharing and learning.

All patients with long term conditions were on a recall list which was managed by two administration staff. They planned the recalls for the whole year for those patients with one and multiple long term conditions. Patients were invited to have all the relevant tests for the monitoring of their long term condition or conditions undertaken during one appointment. When the results came back they were reviewed by one GP who decided on the most appropriate action. The identified administrators supported this work. If follow up was needed appointments were made for patients to be reviewed at the practice by clinical staff who specialised in relevant long term condition areas. For example, the practice had two GPs and a nurse practitioner who specialised in diabetes, a nurse practitioner and a practice nurse who specialised in chronic obstructive pulmonary disease and two asthma nurses. The outcome of this was that patients' needs were monitored and reviewed holistically rather than by their long term condition. Furthermore if patients did not require further intervention, this was not provided. The way in which the recalls for people with long term conditions were managed was structured and capacity was managed over the year.

Patients told us that their long term conditions were reviewed regularly. We received a number of very positive comments from patients on the management and review of their long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. Our review of the clinical meeting minutes and observations during the inspection confirmed that this happened.

The practice had a robust process in place for referrals to be made and monitored. We were told that regular peer review of referrals was made by the GPs with some being discussed at the weekly referral meetings. There were no incidences where agreed patient referrals had not been made by the practice. However it had been identified previously that a number of referrals had not been actioned by the service where patients had been referred to. Following this, a member of administrative staff was responsible for monitoring that referrals had been made and that patients had been seen by the service they had been referred to. This ensured there was a safety net for patients, although the practice encouraged patients to follow up themselves with the service they have been referred to. They were able to provide patients with information about when the referral was made. Clinical staff confirmed they used national standards for the referral of patients with suspected cancers.

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 patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

There was evidence of effective structuring of patient records undertaken by clinicians. This included the use of templates for a range of clinical conditions, which included for example asthma, cardiovascular disease and diabetes.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Protocols were in place for all nursing procedures. This ensured that care and treatment provided was comprehensive, standardised and took into account best practice guidance.

The practice had a system in place for completing clinical audit cycles. A clinical audit is a performance assessment process that identifies the need for improvement then measures performance once improvements have been implemented in order to assess their effectiveness. One clinical audit cycle we looked at aimed to increase the number of women who returned for their intrauterine contraceptive check, three to six weeks after fitting. Amendments were made to the contraceptive template and reception staff were to arrange an appointment for the patient at four weeks, if they had not had a check and had no appointment pending. Although the standard set by the GP was 75% of patients, the repeated audit showed an increase by 20%, to 62% of patients returning to have a check of their intrauterine contraceptive.

The practice worked with their local clinical commissioning group (LCCG) to identify areas for clinical audit. These clinical audits were undertaken by the practice and the outcomes shared with the LCCG. The practice had completed clinical audit cycles for accident and emergency admissions and the number of patients with diabetes on triple therapy where the National Institute for Health and Care Excellence (NICE) guidance was being met. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient gets fair access to quality treatment. Another clinical audit involved patients diagnosed with chronic obstructive pulmonary disease who were prescribed triple therapy in accordance with the NICE guidelines. In 2014, out of 33 patients, two patients were prescribed this outside of the criteria. These patients were then reviewed.

GPs in the practice undertook minor surgical procedures in line with their registration under the Health and Social Care Act 2008 and National Institute for Health and Care Excellence (NICE) guidance. The practice followed the World Health Organisation's adapted checklist for surgery. This included a range of checks which were undertaken to ensure patients' safety. The checks included for example, patient identity, risk factors, allergies and consent. We found that GPs who undertook minor surgical procedures were appropriately trained and kept up to date with their knowledge. They also regularly carried out clinical audits on their results and used that in their learning. We were told about the quarterly audit of infection rates following minor surgery. We were provided with data which showed that in quarter two, 2013, 81 patients had received minor surgery with100% not having an infection post operatively. In, quarter two, 2014, 93 patients had received minor surgery with100% not having an infection post operatively.

Another audit was completed in relation to the documentation of patient consent to minor surgery. An audit completed in September 2011, identified that patient consent was being documented on the electronic patient record as consent given. Improvements were made to ensure that a full written consent form was obtained before minor surgery was undertaken. The health care assistant confirmed that the consent forms were printed at the beginning of the minor surgery clinic, patients signed them and they were scanned onto the patient's record. A re-audit was completed which showed that this was obtained in 100% of patients who had minor surgery.

The practice also collected information for the Quality and Outcomes Framework (QOF) and used their performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (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 e.g. diabetes and implementing preventative measures. The results are published annually. The QOF data showed that the practice scored above the local Clinical Commissioning group (CCG) and England average in all of the clinical indicator groups. These included for example, asthma, cancer, depression, dementia, hypertension, learning disability, stroke, transient ischemic attack and rheumatoid arthritis. In addition they had a higher clinical prevalence than the CCG average in all but three areas and had a lower clinical exception rate than the CCG average.

We saw evidence that patients had received a medication review, which was in line with the expected time dependent on their presenting condition. The patients we spoke with confirmed that their medicines were reviewed regularly. This was also confirmed by the representatives we spoke with from the care homes where patients were registered with the practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Effective staffing

The practice had an induction checklist which was used for all new staff starting work. This included documentation required and confirmation that this had been supplied. For example, registration with a professional body, photographic identification, measles and Hepatitis B status and disclosure and barring service checks. We were told that new staff underwent a period of induction when they first started to work at the practice. The induction programme covered a range of areas including introduction to team members, health and safety, confidentiality and fire safety. On line training was also included in the induction with a timescale of when it should be completed. For example, child safeguarding and fire safety within one week and equality and diversity and manual handling within six months. We saw the completed induction for two members of staff. Staff we spoke with confirmed that they had received an induction.

The practice staff included medical, nursing, managerial dispensing, administrative and locum staff. They also had staff who were undertaking training, which included qualified doctors who were training to be GPs and medical students, who were training to be doctors. The training requirements of each of these staff groups were identified. We reviewed the spread sheet of training which was maintained by the human resources administration lead. We saw that staff had undertaken training, such as basic life support, safeguarding, information governance and equality and diversity. The practice nurse was expected to perform defined duties and was able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and independent nurse prescribing.

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

The practice had an appraisal policy and process in place for its staff. We spoke with seven staff all of whom confirmed they had received an appraisal in the past year. One member of staff we spoke with told us that they had been supported to undertake a business administration diploma by the practice and this had been identified and agreed through the appraisal process. We looked at five staff files and found that four staff had a completed appraisal which had been undertaken in the past year. The member of staff who did not have a completed appraisal had not received one. Once this had been identified, the practice business manager told us that this would be resolved.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. These were reviewed by the individual clinicians and actioned as necessary. The visiting doctor also checked the overall list and checked that all correspondence had been actioned within 72 hours of being received. We saw that the majority of the patient correspondence was dealt with within 48 hours of being received.

The practice was commissioned for the enhanced service and had a process in place to follow up patients discharged from hospital in order to follow up on their care and treatment. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) One person in the practice and the multi-disciplinary team coordinator from the CCG were responsible for this so that this work was coordinated and intervention provided as soon as possible. When the discharge summary was received by the practice, if there was an action needed by a GP, they would follow this up. The visiting doctor was responsible for checking that correspondence was actioned within 72 hours, so if this had not been actioned then they would undertake this work.

The practice held multidisciplinary team meetings on a monthly basis to discuss the needs of complex patients, for example those with end of life care needs, and those who were vulnerable. These meetings were attended by GPs and other professionals as required, according to the needs of the patients being discussed. Decisions about care planning were documented in a shared care record.

Vulnerable children meetings were also held and run by the child and family service. They were chaired by the lead GP

Outstanding ☆

Are services effective?

(for example, treatment is effective)

for safeguarding children and health visitor and schools nurses were represented. They reviewed vulnerable children under five years of age and those on the child protection register.

The practice had a palliative care register and also used the multidisciplinary team meetings to discuss the care and support needs of patients and their families. This included sharing do not attempt resuscitation decisions and patients preferred place of care decisions. The palliative care part of the meetings were usually attended by the GPs, the hospice lead, the community matron and the district nurses. We were told that unexpected deaths were also discussed at the multi-disciplinary team meetings to identify if there was anything that could be learnt or done differently.

The practice worked closely with The John Huntingdon Trust. This was a charity who works in conjunction with the Citizens Advice Bureau. The practice made referrals to The John Huntingdon Trust so that patients, particularly those who were vulnerable, were able to receive support for issues that were not medical in nature. Furthermore, if GP reports were needed for benefit or housing claims, the John Huntingdon Trust commissioned this from the practice in order that patients did not have to pay for this.

Information sharing

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. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

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. The practice used the Choose and Book system for making referrals. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). The practice had 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).

The practice worked collaboratively with other agencies and community health professionals and regularly shared information to ensure timely communication of changes in care and treatment. This included liaison with health visitors, school nurses and mental health services. The safeguarding children GP lead advised that they send reports to child protection meetings, if they were not able to attend in person. The report was usually completed by the GP who knew the family best.

Consent to care and treatment

We saw that the practice had a consent protocol. The clinicians we spoke with described the processes to ensure that consent was obtained and documented from patients whenever necessary, for example when patients needed minor surgery. We were told that verbal consent was recorded in patient notes where appropriate. Patients we spoke with, and received comments from, confirmed that their consent was obtained before they received care and treatment.

Clinicians demonstrated an understanding of legal requirements when treating children. The clinical staff we spoke with demonstrated an understanding of Gillick competency test. This is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions. Information about consent for children was provided for staff in the practice's consent policy.

The practice had Mental Capacity Act policy available for staff. The Mental Capacity Act (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. The GPs and nurses were knowledgeable about the Mental Capacity Act 2005. They understood the key parts of the legislation and their duties in fulfilling it.

Health promotion and prevention

There was some up to date health promotion information available at the practice and on the practice website, with information to promote good physical and mental health and lifestyle choices. The practice website referred patients to a range of information supplied by NHS Choices. This included information on living well, treatments and conditions and health videos. There was an electronic information and advice hub in the main reception area, for the use of patients. This was provided by the John Huntingdon Trust, in conjunction with the Citizens Advice Bureau and was maintained by the practice. This provided details of benefits and support that is available to patients.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

We saw that new patients were invited into the surgery when they registered, to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. If the patient was prescribed medicines or if there were any health risks identified then they were also reviewed by a GP in a timely manner. New patients were given a health passport. This enabled them to keep a record of their health status and to set their own health goals and monitoring towards their goals. Patients could also seek support from the practice to do this. The passport had simple text and illustrations which helped make it simple to follow.

NHS health checks were offered to all patients between the ages of 40-75 years with a 47% take up rate in 2014 to 2015. Appointments were also available for one to one advice on smoking cessation and weight reduction. In addition, patients could be referred to a community health improvement programme, an eight week course on weight loss, which was run in conjunction with the council. Patients could also be referred to Camquit, a smoking cessation group, which was run in conjunction with the practice. The practice ran a walking group every Tuesday which was available for patients.

The practice had numerous ways of identifying patients who needed additional support. The practice kept a register of all patients with a learning disability and offered them an annual health check. On the day of our inspection, we were told that 42 of the 43 patients with a learning disability (98%) had attended for an annual health check in the previous year. The practice also had a register of patients with dementia. We were told that 72 of the 91 patients (79%) with dementia, eligible for a health check had attended for one. There was also a process in place for following up those patients who did not attend for their appointment. They were contacted by text message to advise them that they did not attend for their appointment and to re book their appointment if necessary. However for health checks which usually involved longer appointments, patients were usually contacted and asked why they had not attended. They were then written to and another time given for their appointment. Text reminders were sent out for appointments. Occasionally patients were phoned before their appointment to remind them about it.

We looked at the most recent Quality and Outcomes Framework (QOF) data and noted that the practice had scored higher than the Clinical Commissioning Group (CCG) and England average for cervical screening (100%), child health surveillance (100%), primary prevention of cardiovascular disease (100%) and smoking (99.4%). They scored the same as the CCG and England average for obesity (100%) and contraception (100%).

Information about the range of immunisation and vaccination programmes for children and adults were available at the practice and on the website. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. They were registered as a yellow fever vaccination centre.

The practice encouraged attendance and education for childhood immunisation. Where patients had specific concerns about immunisation, the GP who specialised in children met with them to provide information, in order to support them to make a decision. The childhood vaccination programme at the practice was also led by this GP. Vaccination clinics were scheduled when this GP was at the practice, as they had paediatric resuscitation skills, in the event of anaphylaxis. (A sudden allergic reaction that can result in rapid collapse and death if not treated). Any issues regarding immunisations, for example in relation to patients not attending were reported to the lead GP, so that one person had oversight of this area. We saw that the practice had higher percentages of children who had received vaccination when compared with the Clinical Commissioning Group.

We looked at the latest available data for smoking cessation, which was for the year 2013 to 2014. This showed that the practice was ranked 9th highest in the Clinical Commissioning Group (CCG) area for the number of patients who had been provided with smoking cessation support and followed up. The practice had a process in place which gave responsibility for the clinician who commenced the smoking cessation work to ensure the follow up intervention was undertaken.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

There was a person centred culture at the practice. Staff and management were committed to working in partnership with patients. During our inspection we overheard and observed good interactions between staff and patients. We observed that patients were treated with respect and dignity during their time at the practice. We spoke with four patients and reviewed 22 CQC comment cards which had been completed by patients to tell us what they thought about the practice. Patients told us that staff were caring, they were treated with respect and their privacy was maintained.

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 and clinical room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We spent time in the waiting room and observed a number of interactions between the reception staff and patients coming into the practice. The quality of interaction was consistently good, with staff showing genuine empathy and respect for patients, both on the phone and face to face. 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 reception was located near to one of the waiting areas. There was a notice asking patients to respect other patients' privacy. Staff we spoke with told us that they would ask patients to a private room if they were upset or if they were sharing sensitive information. However there was no notice informing patients that they could request this.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 271 surveys had been sent out with 111 being returned, which was a response rate of 41%. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (90%) and for whether nurses listened to them, 90% reported this as being good or very good. Satisfaction rates for patients who thought they were treated with care and concern by their GP was 88% and for whether the GP listened to them, 91% reported this as being good or very good. 84% of respondents described their overall experience of the practice as fairly good or very good and 84% of patients stated they would recommend the practice. These results were average when compared with other practices in the CCG area.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt fully involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patients reported they had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive and did not feel rushed. We heard examples of where options for treatment were explained in a way that patients understood. Patient feedback on the comment cards we received was also positive and aligned with these views. Representatives from the care homes we spoke with confirmed that the GPs and practice nurses involved patients in their care plans.

Data from the national GP patient survey, published on 8 January 2015, showed 82% of practice respondents said the GP involved them in care decisions, 87% felt the GP was good at explaining tests and treatments and 88% said the GP was good at giving them time. These results were average or slightly higher, when compared with other practices in the Clinical Commissioning Group (CCG) area. In relation to nurses: 83% said they involved them in care decisions; 89% felt they were good at explaining tests and treatments and 91% said they were good at giving them enough time. These results were average and slightly higher when compared with other practices in the CCG area.

Patient/carer support to cope emotionally with care and treatment

Information leaflets for carers were available in the waiting room, although these were not easily accessible. Information for carers was also available on the practice's website and included videos, for example, about supporting someone through mental illness, caring for more than one person and palliative care at home.

One of the administration staff was the lead for carers. When a new patient registered at the practice they were

Good

Are services caring?

asked if they were a carer or had a carer and were asked to complete a carer's identification form. Following receipt of this information the practice identified them on the computer system. If the carer or cared for had specific needs then this was also documented on the patients record. For example, if the patient preferred a telephone call to written information, as they found this easier to understand.

The practice took part in the Carer's Prescription Service. When GPs identified patients in their practice who provided care to others, they could write a prescription for them which could be 'cashed in' by the carer to access a specialist worker at Carers' Trust Cambridgeshire for support, information and respite care.

Staff told us that if families had suffered bereavement, the practice either sent a card offering the practice's condolences or contacted families directly depending on the situation. In addition to the support provided by the practice staff, we were told that patients were referred to local external organisations that provided counselling services. We were also told that patient and family member's records were updated so no inappropriate contact was made.

Outstanding ☆

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 practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs. Patients we spoke with on the day of our inspection told us they were satisfied that the practice was meeting their needs. Comment cards left by people visiting the practice prior to our visit also reflected this.

The current appointments system had been restructured five years ago in order to respond to patient need and demand. Staff and patients we spoke were satisfied that this approach continued to work well. This included a rapid access clinic, staffed by one GP, one nurse practitioner and a visiting GP, for patients with an urgent need to be seen that day. A visiting GP was available for home visits from 8:00am to 6:00pm. Home visits could be accommodated earlier in the day in order to maximise time to put support in place for those patients, in order to minimise the need for a hospital admission. Patients from the practice were amongst the lowest users of the NHS 111 service within the Clinical Commissioning group (CCG). (The NHS 111 service is for when people need help fast, but it is not a life-threatening 999 emergency.) We were shown data which identified that the practice accident and emergency attendance rate was 65.86 per thousand patients, compared with the national average of 82.26 per thousand patients. The practice business partner and the GPs we spoke with commented positively that since the introduction of the rapid access clinic, the number of telephone calls in the morning had drastically reduced.

The practice provided an ear micro suction service for its patients and also non-registered patients. This was requested by the CCG due to a lack of provision in the area. This also reduced the need for patients to travel to a hospital clinic. The practice had trialled opening the surgery on Easter Saturday to provide patients with an alternative to visiting the accident and emergency department.

The practice delivered medicines to some villages, where there were central collection points. Staff also delivered medicines to some patients who were housebound and were extending this to patients who had difficulty in collecting their medicines. Staff who delivered these medicines had undertaken a Disclosure and Barring Service check to help ensure their suitability for undertaking this role.

Representatives of the PPG told us they were listened to by the practice and the practice had implemented suggestions for improvements in response to their feedback. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. We spoke with one member of the PPG, who told us that all staff now wear name badges. They also advised that the practice were planning to get photographs of staff displayed. Their idea for a newsletter had been approved by the practice and we also noted that work had been undertaken to redesign the practice website.

Tackling inequity and promoting equality

The practice had an equal opportunities/ anti-discrimination policy. The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. Staff told us that the vast majority of patients registered with the practice were English speaking. However, translation services were available for patients who did not have English as a first language, although they did not have many patients registered who needed this service. We were told that for patients who needed this service, this was identified on their patient record and appropriate arrangements made. Longer appointments were available for people who needed them, which included patients with long term conditions or those who needed to use an interpreter. Home visits were available to patients who could not attend the practice. In addition home visits to patients living at three local care homes were made, both on a regular basis and when this was requested by staff at the care home.

The practice was situated in a one story building. There were automatic opening doors at the front of the practice. All the GP and nursing staff were based on the ground floor. The rooms upstairs were generally used by other health services, for example there was a physiotherapy gym

upstairs which patients may be referred to. A lift was available for patients to access the first floor rooms. An induction loop was available for patients who had difficulty hearing and we noted that assistance dogs were welcome.

The waiting areas were situated in different areas of the practice. They were large enough to accommodate patients with wheelchairs and prams. There was suitable access for people with mobility needs, to all the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. There was also a separate baby feeding room for the use of patients.

Access to the service

The practice opened every week day. The practice had extended its opening hours in response to increased patient numbers and patient need. It was open on Monday, between the hours of 8:00am to 8:00pm, Tuesday to Thursday from 8:00am to 6:00pm and on Friday from 7:00am to 6:00pm. Consultations with GPs and nurses were available from 8:30am to 11:30am and from 2:00pm to 7:40pm on a Monday, from 8:30am to 11:30am and from 2:00pm to 5:30 pm on Tuesday, Wednesday and Thursday and from 7:00am to 11:30am and from 2:00pm to 5:30pm on a Friday. These times were particularly useful to patients with work commitments. Patients could make appointments by telephone, at the surgery, or online. Repeat prescriptions could be ordered online.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice had a designated visiting GP who was available for home visits from 8:00am to 6:00pm. Home visit requests were assessed and prioritised according to clinical need by the GP. This enabled the practice to respond effectively to patient need. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 271 surveys had been sent out with 111 being returned, which was a response rate of 41%. We found that 76% of patients described their experience of making an appointment as good and 93% said the last appointment they got was convenient. These results were in line with other practices in the Clinical Commissioning Group. Comments received from patients on the day of the inspection showed that patients in urgent need of treatment had been able to make appointments on the same day of contacting the practice. They confirmed that they could see another GP if there was a wait to see the GP of their choice. We noted that routine appointments with clinicians were available in three days time. The care home representatives we spoke with confirmed that requests for home visits were responded to in a timely way.

Listening and learning from concerns and complaints

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

There was information on making a complaint in the practice patient information leaflet and on the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint but they believed that any complaint would be taken seriously.

We looked at the complaints procedure for the practice. This encouraged the timely resolution of complaints by offering patients the opportunity to speak with the practice business manager when patients raised a verbal complaint or concern. Staff we spoke with on reception confirmed that they would escalate any patient complaint or concerns to the practice business manager. The practice business manager informed us that if a verbal complaint identified a significant issue, then they would record this and respond to it as a written complaint in order to ensure it was investigated, reviewed and learning undertaken as appropriate. The complaints procedure included information on how to raise or escalate complaints to the Clinical Commissioning Group, NHS England and/or The Parliamentary and Health Service Ombudsman. A copy of the complaints procedure was sent to patients with the response letter from the practice acknowledging their complaint.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had received 19 written complaints from 1 April 2014 to 31 May 2015. We reviewed five complaints which had been received during this time. These had been acknowledged, investigated and a response had been provided to the complainant, in line with the practice complaints policy. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate.

The practice discussed and reviewed complaints at the weekly executive meetings in order to identify learning and areas for improvement. These were shared with the individuals involved in a timely way. The learning identified was then shared as appropriate at the different meetings in the practice. The practice had implemented learning from complaints to improve the service offered to patients. For example the procedure for informing the visiting GP of home visit requests and further updates from patients or their representatives had been improved. This was to ensure that the GP was kept informed of all updates in relation to patients and that there was a clear audit trail of this.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision: 'to endeavour to continuously improve itself to provide an efficient, effective range of healthcare. Innovation, team work and responsibility will continue to enthuse us and those we connect with and the standards achieved will be a beacon for others to follow.' We found details of the vision and practice values were part of the statement of purpose for the practice. These values were displayed in the waiting room. The practice values included: 'treating everybody with respect, compassion and integrity. Maximising the potential of our workforce through the nurturing of individual skills and creativity and the creation of a healthy working environment. Promoting excellence through collaborative working, on-going education and teaching.'

We spoke with a number of staff and they all had an awareness of the vision and values and knew what their responsibilities were in relation to these. We spent some time observing staff and saw evidence that these values were demonstrated in their interactions with colleagues and patients.

There was also a practice charter which outlined what the staff at the practice would do and what they expected from patients. A copy of this was in the 'Sawston Medical Practice patient information leaflet, a brief guide to our services.'

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available on the shared drive of the computer system in the practice. We spoke with a number of clinical and non-clinical staff, all of whom knew where to find these policies if required. We looked at a sample of these policies and procedures and they were in date and had a date for review. There was a process in place for policies to be reviewed and agreed before being implemented.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. 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 e.g. diabetes and implementing preventative measures. The results are published annually. The practice staff set monthly internal targets and monitored their monthly performance towards meeting the annual QOF targets. One of the staff who had responsibility for monitoring this told us that where performance against the monthly target dipped, actions were identified and implemented in order to improve performance. The practice was performing in line with or above national standards for all areas of QOF. The practice achieved a 98.3% score (of total available points) which compared with the local Clinical Commissioning Group average of 89.3% and the England average of 93.5%.

The practice had arrangements for identifying, recording and managing risks. Many of these risks were identified and managed by staff with responsibility for these areas. For example, health and safety risk assessments and checks of the building were undertaken by the facilities lead. Any risks identified which needed to be escalated were discussed both informally and formally at the weekly executive team meeting for discussion and decision.

The practice had arrangements for identifying, recording and managing significant events and for the management of complaints. Processes were in place to ensure these were discussed and investigated by the appropriate staff. Arrangements for sharing the learning across departments as appropriate were also robust.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. There were identified heads of departments, staff with identified areas of responsibility and staff with lead responsibility. For example, there was a lead nurse for infection control, a GP lead for children and child safeguarding. Another GP was the lead for mental health. We spoke with a number of clinical and non-clinical members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, very well supported and knew who to go to in the practice with any concerns. The practice aimed to have a non-hierarchical structure and staff we spoke with confirmed that this was the case.

There were a number of meetings held at the practice in order to share information, learning and provide support for staff. These included for example, separate meetings for different groups of staff, including clinicians, GPs, nurses and heads of department. The whole practice team also met annually. The practice business manager and two GP partners also met weekly, as an executive team. Staff told us that there was an open culture within the practice and

Are services well-led?

Outstanding ☆

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

they had the opportunity and were happy to raise issues with their manager, with the practice business manager, or the GPs and at team meetings. There was a willingness to improve and learn across all the staff we spoke with. We were told by the practice business manager that when there was a collective achievement by staff at the practice this was celebrated by having a donut day or other staff treat.

A weekly staff newsletter was written which provided details of meetings that had been held during the week and feedback of actions from audits and health and safety information. The newsletter also included information on positive achievements of staff, training opportunities, links to newsletters for other organisation and other updates within the practice. Staff we spoke with told us that this was a useful way of keeping up to date with what was happening within the practice.

Seeking and acting on feedback from patients, public and staff

We found the practice were proactive in obtaining feedback from patients in order to ensure that it responded appropriately to their needs. For example, we noted that the practice were currently consulting patients for their preference on three different extended opening hours options. This was being undertaken on the practice's website. This was as part of a bid to secure additional resources to provide extended GP hours plus urgent care provision for South Cambridgeshire practices. We were informed that the practice were not successful in their bid but that feedback from patients would be listened to when the practice was in a position to extend the opening hours. We also saw and heard examples of how the practice listened and responded in a timely way to formal and informal feedback from patients. This had been done through patient surveys and patient feedback, the friends and family test, the patient participation group and complaints.

The practice had an active patient participation group (PPG). (This is a group of patients registered with a practice who work with the practice to improve services and the quality of care.) The practice also had a virtual PPG who were consulted by email on specific issues which related to its work. The PPG met regularly with representatives from the practice and had supported with providing patient feedback. We looked at the 2015 to 2016 action plan, which was available on the practice website. The PPG had identified five areas that the practice agreed to focus on to improve patient experience. One of these areas related to consistency in waiting times with the target being that 90% of patients would be seen within 15 minutes of their booked appointment time. We noted that this data was reported monthly on the website and on the practice screens. We reviewed the data which showed that improvements had been made. In May 2012, 88% of patients were seen within 15 minutes of their booked appointment time. In May 2013 this was 91%, in May 2014 this was 90% and in May 2015 this was 91%. Patients we spoke with and received comments from confirmed that waiting times had improved.

The practice collated feedback from patients from the 'friends and family' test, which ask patients, 'Would you recommend this service to friends and family?' The friends and family feedback form was easily accessible in the waiting room for patients to complete. We noted that the practice had also received feedback by smart phone/ online. We were provided with the following data from the practice. 13 responses had been received in January 2015, with 93% of patients saying they would recommend. In February, two responses were received and in March, one response was received both with 100% recommending. In April, 2 responses were received with 50% recommending the practice to family and friends.

We looked at the most recent staff survey, which was undertaken in April 2015. This had been completed by 38 of the 39 staff employed at the practice. The majority of staff rated the practice as good or excellent for both staff and patients for standard of care and as a place to work. There was an increase in the number of staff who rated the practice as an excellent place to work from the 2014 survey to the 2015 survey. However there was a reduction in the number of staff who marked happiness at work as excellent. The partnership team had identified this and had asked staff for ideas on how happiness could be improved. One action they had identified and were planning to implement was increasing the competence of the lead GP in terms of encouraging improved team working in the rapid access clinic. The practice had also held ad hoc social events, however these have now been planned more regularly, so that there is some social event every four to six weeks. The practice business manager told us that following the first staff survey in 2014, the staff newsletter

Are services well-led?

Outstanding ☆

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

was introduced to improve communication and the sharing of information within the practice. There was evidence that the practice obtained and responded to feedback from staff.

The staff we spoke with described the working environment as friendly and supportive and that they felt valued. We were told they felt that any suggestions they had for improving the service would be taken seriously and would be listened to. We were told by the practice business manager, that one member of staff suggested a regular clinic for blood monitoring which was agreed by the practice. 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 shared drive on the practice's computer system. Staff we spoke with were aware of the whistleblowing policy or where they would be able to find a copy. Staff we spoke with felt that they were easily able to raise any concerns and that they would be listened to.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They commented positively on the clinical support they could easily obtain from the GPs and each other. All the staff we spoke with told us they had had an appraisal in the previous 12 months and records we saw supported this. Clinical staff told us that they attended external clinical and peer support meetings. Learning from these meetings was shared at the weekly clinical meetings. Nurses we spoke with told us that they could access support from the GPs and advanced nurse practitioners and the advanced nurse practitioner also facilitated reflective practice sessions for staff. The practice also closed for staff training on a quarterly basis.

The practice was a teaching practice and two of the GPs were registered as GP trainers. The practice were currently supporting two GP Registrars, who were qualified doctors training to be GPs. They were provided with weekly tutorial time with the GP trainer, had training from GPs with special interests and had access to all the GPs for advice and support. Time was also given to talk through cases at the end of surgery, to provide support and learning. When they saw patients, they were initially given extended appointments. They were encouraged and when they felt ready, to reduce the length of time of each appointment, in order to support them with the expectation of general practice.

The practice had completed reviews of significant events and other incidents and shared with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. The results of feedback from patients, through the patient participation group, patient feedback board, family and friends test, comments and complaints were also used to improve the quality of services. Compliments and positive responses from patients following complaints were shared with the practice team in order to positively reinforce the learning.