Waterbeach Surgery

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We visited Waterbeach Surgery on the 20 May 2015 and carried out a comprehensive inspection.

The overall rating for this practice is good. We found that the practice provided an effective, caring, responsive and well led service. Improvements were needed to ensure patients were kept safe.

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.

Our key findings were as follows:

- Patients told us they were treated with dignity, care and respect. They were involved in decisions about their care and treatment and were highly complementary with 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 care tailored to their individual needs.
- Patients were satisfied with the appointment system and many of the patients reported they were able to see a GP on the same day. They commented positively on the availability of telephone consultations, early morning and early evening appointments.
- The needs of the practice population were understood and services were offered to meet these. Feedback from care home representatives was very positive, particularly in relation to support for patients with mental health needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

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- There was scope to improve arrangements in relation to the safe management of medicines by ensuring the dispensary is only accessed by authorised staff and regular auditing of controlled drugs.

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

- Ensure that robust processes are in place to assess the risk of and prevent, detect and control the spread of infection, including those that are health care acquired. The flooring in a clinical room was not appropriate in order to effectively control the spread of infection.

In addition the provider should:

- Improve the security of the dispensary to reduce the risk of unauthorised access. This includes unauthorised access to prescription pads.
- Ensure regular audits of controlled drugs are undertaken.
- Ensure there is a robust process for checking that actions for improvement identified through significant events and complaints are completed. Near miss incidents in the dispensary should also be reported to ensure learning can be undertaken and action undertaken to minimise the risk of reoccurrence.
- Ensure that the arrangements and agreements detailed in the business continuity plan are in place.
- Ensure all staff receive an annual appraisal.
- Undertake a formal legionella risk assessment.
- Ensure all staff receive fire training every year as detailed in the fire precautions policy for the practice.
- Ensure regular inspections of the building are undertaken, as planned.

We saw one area of outstanding practice:

- The practice used pictorial guidance for patients to remember when to take their medicines. Different times of the day were depicted and the corresponding number of tablets drawn to represent the number of tablets the patient needed to take at those times. Patients with visual impairment who needed inhalers were prescribed differently shaped inhalers to enable them to tell the difference between their medicines.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. However, this should include near miss incidents in the dispensary. Lessons were learned from significant events and complaints and shared to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed although a legionella risk assessment had not been fully completed at the time of the inspection. Regular inspections of the building were being planned. Staff had a good understanding of the types of abuse and their responsibilities in relation to safeguarding. Information was provided to support staff in relation to safeguarding children and adults. The practice had suitable equipment to diagnose and treat patients and medicines were handled safely. There was scope to improve arrangements in relation to the safe management of medicines by ensuring the dispensary was only accessed by authorised staff and regular auditing of controlled drugs. Improvements were required to ensure that robust processes were in place to assess the risk of and prevent, detect and control the spread of infection, including those that are health care acquired. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were average or above 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. We saw evidence of effective multidisciplinary working. Staff had received training appropriate to their roles and further training needs had been identified and planned for. The majority of staff had received annual appraisals and dates had been arranged for those staff who were due to have an appraisal. The provider recognised that their procedures for the documentation of induction of staff needed improvement and they had developed a checklist which they planned to use with new staff joining the practice.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others in the locality for several aspects of care. Where data had been below average for the locality, action had

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been taken to ensure improvement. Patients we spoke with and received comments from told us they were treated with compassion, dignity and respect. They were listened to by all staff and involved in care and treatment decisions. Feedback from patients was extremely complementary. Accessible information was provided to help patients understand the care available to them. We also observed that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed and addressed the needs of their local population. 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 used their limited space effectively. They were well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision and staff were aware of their responsibilities in relation to this. There was a clear managerial and clinical leadership structure and staff we spoke with felt supported in their work. The practice had a number of policies and procedures to govern its activity, although not all of the policies had been dated and approved. Regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients and this had been acted upon. Staff had attended staff meetings and peer support meetings and the majority had received an annual appraisal.

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The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes 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, including offering morning home visits and rapid access appointments for those with enhanced needs. The on call GP at the practice reviewed the out of hour reports early in the morning. This ensured that patients who needed to receive intervention from a GP were identified early and intervention undertaken to meet their needs. Changes had been made to the appointments system so the GPs could undertake home visits to vulnerable and frail elderly patients earlier in the day. This enabled them to have more time to engage appropriate care and support according to the patients' needs. Flu vaccination uptake was above average when compared with other practices in the Clinical Commissioning Group.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. 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. The practice offered nurse led clinic appointments for a number of long term conditions, including chronic obstructive pulmonary disease and diabetes. All patients with long term conditions had structured reviews, at least annually, to check their health and medication needs were being met. Patients with multiple long term conditions were reviewed in one extended appointment. 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 midwife led clinic was available for patients on a weekly basis. A recall system was in place for the mother and baby

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six week check. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.Chlamydia screening was above average when compared with other practices in the Clinical Commissioning Group.

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 on Tuesday mornings each week from 6.45am to 8am and Wednesday evenings each week from 6.30pm to 7.45pm. The practice offered same day telephone consultations for non-urgent medical matters where patients felt a visit to the practice was not necessary. A full range of health promotion and screening which reflects the needs for this age group was also available. Flu vaccination uptake was above average for patients aged under 65 and at risk, when compared with other practices in the Clinical Commissioning Group.

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 75% 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 people who needed an interpreter. There were arrangements for supporting patients whose first language was not English. 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. 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.

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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 below the England average for people with mental health needs. They scored lower than average for patients with dementia, although the GPs felt this was a recording issue, rather than intervention not being undertaken. 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. We found the knowledge of the GPs in relation to mental health was good and patient representatives we spoke with confirmed this. Patients were referred to other mental health services as appropriate.

Summary of findings

What people who use the service say

The practice had informed patients that CQC were visiting on the 20 May to undertake an inspection. Patients had been invited to attend the surgery on the day of the inspection to share their views or leave a comment on the cards provided by CQC which were found on the reception desk.

We spoke with nine patients during our inspection. All of the patients told us that they were able to get an appointment easily and on the same day. They commented positively on the early and late appointment availability and the ability to request a telephone call from the GP. They report that they had sufficient time with the GP and nurses and were not rushed during their consultation. 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. Many of the patients told us that staff at the practice had a friendly, human approach which made them feel safe and cared for.

Our comments box was displayed prominently and comment cards had been made available for patients to share their experience with us. We collected 37 Care Quality Commission comment cards. The majority of the comments on the cards were positive about the practice. Patients reported that all the staff were friendly, helpful and caring. Some of the patients had been registered at the practice for many years and had always been satisfied with their care and treatment. The majority of patients reported that they were able to get an appointment easily, although two patients were dissatisfied with the wait for a routine appointment. Another patient reported that there could be a wait for the telephone to be answered when the surgery opened.

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, especially if patients did not have mental capacity to consent. Patients with long term conditions were monitored and reviewed in their home by the named GPs regularly. One care home representative told us that practice staff were knowledgeable about the Mental Health Act and supported patients with mental health needs well. We were provided with a number of positive examples of when referrals had been made in a timely way and were advised that the practice worked well with other services, in particular the community psychiatric nurse. There were no concerns reported regarding repeat prescriptions and representatives knew how to complain if they needed to.

Areas for improvement

Action the service MUST take to improve

- Ensure that robust processes are in place to assess the risk of and prevent, detect and control the spread of infection, including those that are health care acquired. The flooring in a clinical room was not appropriate in order to effectively control the spread of infection.

Action the service SHOULD take to improve

- Improve the security of the dispensary to reduce the risk of unauthorised access. This includes unauthorised access to prescription pads.
- Ensure regular audits of controlled drugs are undertaken.
- Ensure there is a robust process for checking that actions for improvement identified through significant

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events and complaints are completed. Near miss incidents in the dispensary should also be reported to ensure learning can be undertaken and action undertaken to minimise the risk of reoccurrence.
- Ensure that the arrangements and agreements detailed in the business continuity plan are in place.
- Ensure all staff receive an annual appraisal.
- Undertake a formal legionella risk assessment.
- Ensure all staff receive fire training every year as detailed in the fire precautions policy for the practice.
- Ensure regular inspections of the building are undertaken, as planned.

Outstanding practice

- The practice used pictorial guidance for patients to remember when to take their medicines. Different times of the day were depicted and the corresponding number of tablets drawn to represent the number of tablets the patient needed to take at those times. Patients with visual impairment who needed inhalers were prescribed differently shaped inhalers to enable them to tell the difference between their medicines.

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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 practice manager specialist advisor, a medicines management inspector and two CQC inspectors who observed.

Background to Waterbeach Surgery

Waterbeach Surgery, in the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area, provides a range of general medical services to approximately 4500 registered patients living in Waterbeach, Landbeach, Horningsea, Clayhithe, Chittering & Milton.

According to Public Health England information, the patient population has a slightly higher than average number of patients aged 0 to 4 and a slightly lower than average number of patients aged 5 to 18 compared to the practice average across England. It has a slightly lower number of patients aged 65 and over, and a slightly higher number of patients aged 75 and over compared to the practice average across England.

Income deprivation affecting children is significantly lower and in relation to older people is slightly lower than the practice average across England. A slightly lower percentage of patients had a caring responsibility compared to the practice average across England.

There are two GP partners who hold financial and managerial responsibility for the practice. There is one salaried GP, two practice nurses, a health care assistant and a phlebotomist. There are also receptionists and administration staff, a maintenance person, a cleaner, an office manager and a practice manager. The practice has a dispensary and one dispenser.

The practice provides a range of clinics and services, which are detailed in this report, and opens between the hours of 8:30am and 6pm weekdays, with a lunchtime administrative closure between 1pm to 3pm. The practice duty doctor could be contacted during this time. Early morning appointments are available Tuesday mornings from 6.45am to 8am and Wednesday evenings from 6.30pm to 7.45pm

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 visit on 20 May 2015. During our visit we spoke with a range of staff, including two GPs, two nurses, a health care assistant, a dispenser, the office manager and the practice manager.

We spoke with seven 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 nine patients who used the practice. We reviewed 37 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

Requires improvement

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 and significant events that had occurred during the last three years and we were able to review these. One complaint we reviewed related to the prolonged waiting time to see the nurse, following the patient's appointment time. The investigation showed that sufficient time had not been scheduled for the nurse appointments so longer appointments were now scheduled according to the reason for the nurse appointment. Records showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events and incidents. Clinical and non-clinical staff were aware of the system for raising significant events and felt encouraged to do so. Significant events and complaints was a standing item on the quarterly practice meeting agenda and we saw evidence that significant events and complaints were discussed. These were also discussed at the weekly partners meeting. We noted that there was not a robust system in place to check that actions had been completed. We spoke with the provider about this and they advised us they would review whether actions from past significant events and complaints had been completed at future meetings.

We saw that the practice had completed 11 significant event analyses from 1 April 2014 to 31 March 2015. We looked at the records of significant events and saw these had been completed in a comprehensive and timely manner. We looked at a sample of significant event analyses and saw evidence of action taken as a result. One significant event we reviewed related to an error with a prescription which had been completed by a non-clinical member of staff. We saw that any new prescriptions were now checked against the hospital discharge letter to reduce the risk of prescribing error. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. This occurred through one to one conversations with appropriate staff and also via the quarterly practice meetings.

National patient safety alerts were disseminated by the practice manager to staff by email and hard copy. Staff also told us alerts were discussed at relevant meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had 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. There was a separate folder which contained safeguarding information which staff we spoke with were aware of. 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. We noted that the practice had recently been involved in a safeguarding children audit and were working towards making improvements in relation to their safeguarding policy and computer coding in this area.

The practice had appointed a dedicated GP as the lead in safeguarding vulnerable adults and children. They had been trained to level three, as had the other GP partner and could demonstrate they had the necessary training to enable them to fulfil this role. Nursing staff had received training to level two and there were plans to train them to level three. All staff we spoke with were aware who these lead for safeguarding was 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. The practice had recently started using a new computer system so this work was being progressed. There was a process in place for following up patients who did not attend for their appointment. However staff

reported that as they knew the needs of many of their patients, they were proactive in reminding vulnerable patients about their appointment in advance, by telephoning them.

There was a chaperone policy and patients we spoke with were aware they could request a chaperone, although there were no notices informing patients that this service was available. 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). Clinical staff who acted as chaperones had 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. However, they told us they did not document when they had acted as a chaperone, which they should do according to their chaperone policy. We did not see evidence they had received training for this role.

Medicines management

The practice had monitored and assessed some aspects of the quality of its dispensing service by a patient survey which showed patients were pleased with the service. Patients received their repeat prescriptions promptly and did not experience delays in the supply of their medicines. Prescriptions were reviewed and signed by a GP before they were given to the patient. We noted that the dispensary where medicines were stored was well organised. We looked at the arrangements for the security of prescription forms and medicines in the dispensary and advised that security improvements were needed to ensure they could only be accessed by authorised members of staff. Improvements were also needed to track blank prescription forms through the practice in accordance with national guidance.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. There were arrangements in place for the destruction of controlled drugs. However, we checked a sample of controlled drugs and found record-keeping discrepancies in registered records which meant we could not account for all controlled drugs. We were told that staff undertook regular audits of controlled drugs but there were no recent records about this.

There were regular practice meetings to discuss significant events including when there were prescribing incidents and some dispensing errors. However, by talking to staff we established that near-miss dispensing errors had not been recorded so trends of these errors could not be monitored and actions taken where necessary.

Processes were in place to check medicines in the dispensary were within their expiry date and suitable for use. Medicines for use in an emergency in the practice and in doctor's bags 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.

The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality dispensing services to patients. Dispensary staffing levels were in line with DSQS guidance. Whilst some staff involved in the dispensing of medicines had not attained suitable qualifications we were assured that GP's routinely checked all medicines before they were handed to patients.

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. The practice employed their own cleaner who worked three hours every day. 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. Spillages and samples were dealt with by clinical staff only and there was a policy in relation to this. One of the nurses had responsibility for undertaking monthly checks of the cleaning and records were kept which demonstrated that this happened.

Requires improvement

Are services safe?

The practice had a lead for infection control who had undertaken further training to enable them to provide advice to the practice on infection control. A hand washing audit had been completed for clinical staff and it was planned for this to be discussed with reception staff at the next staff meeting in June 2015. We saw evidence that the lead had carried out an extensive infection control audit in October 2014 and that improvements had been identified for action. We noted that the actions of the audit had been agreed by the partners. We saw evidence that some of the areas identified for action had been completed. For example the use of disposable curtains in the practice. The audit and the infection control lead reported that they had raised the need for improved flooring in the phlebotomy room, although this had not been addressed. This room is a clinical area and was fitted with carpet. Flooring in clinical areas should be seamless and smooth, slip resistant, easily cleaned and appropriately wear resistant. We spoke with the provider about this and they agreed that they would ensure that the flooring in this clinical area was appropriate.

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 hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice manager told us they had completed a risk assessment for legionella, although this had not been documented. Legionella is a term for particular bacteria which can contaminate water systems in buildings. They advised that all the taps in the building were used on a regular basis. There were aware that a more formalised risk assessment was needed and this had been added to a risk log of actions which the practice needed to action on a more formal basis.

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 and displayed stickers indicating the last testing date. This had been undertaken in April 2015. We saw evidence of calibration of medical equipment including weighing scales which had been calibrated in September 2015.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that references, qualifications and criminal records checks through the Disclosure and Barring Service (DBS) had been obtained. We noted that proof of identification had not been obtained. We identified that there was no process in place to check that nurses had up to date registration with the appropriate professional body. We spoke with the provider about this and they provided us evidence the day after the inspection that the nurses were registered appropriately. The practice manager also advised us that they would now undertake an annual check with each nurse, to check that they had updated their registration.

Staff told us about the arrangements for planning and monitoring the number and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place 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 reception staff to cover each other's annual leave. GP cover for annual leave was provided by a regular locum GP. The nurses covered for each other and during times of sickness patients with the most urgent needs were prioritised and those with non-urgent needs were asked if they minded having their appointment rescheduled.

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 medicine reviews for patients, handling and responding to national patient safety alerts, dealing with emergencies and the servicing, maintenance and calibration of medical equipment. We saw that staff were able to identify and respond to changing risks to patients including deteriorating health

and well-being or medical emergencies. For example staff were able to give examples of the actions they would take for patients waiting in the reception area whose health rapidly deteriorated.

The practice had a risk assessment table, which identified a number of hazards. These included fire safety, general office, control of substances hazardous to health (COSHH), sharps, electrical appliances and drug handling. For each of these hazards, the following areas had been completed, who was at risk, the likelihood of occurrence, the severity of the risk, risk evaluation, control measures and timescale.

The practice had a health and safety policy and there was an identified health and safety lead. The practice had identified the need for regular inspections of the building and they had planned for this to be completed by the maintenance person. This was identified as an action on the practice's risk log where identified risks were recorded. This included areas of work which needed to be completed although there was no timescale given for when the work would be completed.

We saw that any newly identified risks, including risks to patients, significant events, complaints or infection control were discussed at the weekly partners meetings and at the quarterly practice meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told that all staff had undertaken basic life support training. We looked at three staff files, which showed that this had been completed and staff we spoke with confirmed this. 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 monthly.

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. We found that one medicine was out of date. However we were told there was a national issue with supply and the practice had made a decision that it would be better to have this out of date medicine than not have it available at all. We saw an email from the supplier which advised that they were not able to obtain new stock of this medicine. All the other medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. This identified a number of risks including for example, loss of building, loss of electrical power, and loss of the telephone system. Actions were recorded to reduce and manage the risk. The document also contained relevant contact details for staff to refer to. However we found that copies of the plan were not kept off site as they should have been according to the plan. There was also a reciprocal agreement with another practice, although a hard copy of their business continuity plan was not kept at this practice and it was unclear whether the other practice held a copy of the plan for Waterbeach Surgery either. We spoke with the provider about this and they advised they would keep copies off site and talk with the other practice to ensure that robust arrangements were in place as detailed in their business continuity plan.

The practice had a fire precautions policy and had carried out a fire risk assessment that included actions required to maintain fire safety. We saw records of checks of the fire fighting equipment and fire alarm and checks were due, and had been booked for May 2015. Manual fire alarm test points had been checked weekly and these had been recorded. We saw evidence of a recent fire drill on 14 May which had been successful and learning points had been identified and actions taken to ensure these were shared with practice staff. The fire precautions policy stated that all staff would receive fire training once a year. We looked at three staff files and there was evidence of fire training in two of the files.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. These were shared by email and hard copy and were also shared at clinical and nurse 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 nurses lead in specialist clinical areas such as diabetes and chronic obstructive pulmonary disease. This is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections. Patients told us that they were reviewed regularly for their long term conditions. We received a number of very positive comments from patients on the knowledge of the nurses who undertook these reviews.

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 nurses meetings confirmed that this happened.

The practice had a robust process in place for referrals to be made and monitored. We saw data which showed that the practice performed in line with or above for GP referred first outpatient appointments for the majority of specialities. We were told that regular peer review of referrals was made at the weekly partner meetings.

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

Management, monitoring and improving outcomes for people

There was evidence of effective structuring of patient records which was undertaken by clinicians. This included the use of templates for a range of clinical conditions, which included for example chronic obstructive pulmonary disease, cardio vascular disease and diabetes. 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. One audit we looked at related to the prescribing of antibiotics at the practice. Antibiotics are important medicines for treating bacterial infections. Antibiotic resistance is caused by overusing and inappropriate prescribing. The first audit identified that one antibiotic was found to be used as a first line treatment on some occasions rather than being used as a second line treatment. Information was shared with GPs, reminding them of antibiotic prescribing guidance and the appropriate use of first line antibiotics. The audit had been repeated and identified an improvement in the appropriate prescribing of antibiotics, in line with the prescribing guidelines. We looked at one completed clinical audit which related to patients with chronic obstructive pulmonary disease and whether they had an individualised management plan and rescue medication in place. We saw that when the audit was repeated, there had been an increase in the number of patients who had these in place.

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. 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, although we did not see these.

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 higher or the same as the local Clinical Commissioning group (CCG) and England average for the way it treated the majority of the clinical areas. This included for example, asthma, cancer, depression, learning disability, stroke and transient

ischemic attack. They scored below the CCG and England average for dementia, hypertension and rheumatoid arthritis. The practice reported that the nurses at the practice had been in post for just over a year and that they expected their QOF data to be improved for the 2014 to 2015 year.

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.

Effective staffing

The practice had an induction checklist which was used for all new staff starting work. This covered a range of areas including introduction to team members, health and safety, confidentiality, infection control, equality and diversity and communication skills. We were told that new staff underwent a period of induction when they first started to work at the practice. However this was not formally documented. The practice had developed an induction checklist which would be used for new staff joining the practice, so that their induction was documented.

The practice staff included medical, nursing, managerial dispensing and administrative staff. We reviewed three staff files and 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 and cervical cytology.

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. The practice manager told us that the nurse appraisals were due and these had been scheduled to occur in June 2015. We spoke with staff who confirmed they had received an annual appraisal or that their appraisal was scheduled.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy which outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers. We were told that information from the out of hours GP service was reviewed early in the day by the on call GP. This was so that patients who needed to be followed up were prioritised. The GP who saw these documents and results was responsible for the action required. 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. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract.) We were told that a GP contacted each patient within two days, and usually within one day of them being discharged from hospital, in order to follow up on their care and treatment. We saw that the process in place for responding to hospital communications was working well in this respect.

The practice held multidisciplinary team meetings on a four to five week 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. 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.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was

Good

Are services effective?

(for example, treatment is effective)

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. Representatives from two care homes that we spoke with commented positively on the working relationship the GPs had with the community psychiatric nurse.

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 computer system had recently changed and staff were getting used to the new system. Patients reported that they were aware that the computer system had changed. They reported that staff at the practice had managed well with the change and it had not had a detrimental impact on their care whilst staff were learning the new system.

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.The practice had a confidentiality (teenager) policy which was available to staff and also to patients via the practice website.

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. We found that the knowledge of the nursing staff in this area could be improved. The GPs were knowledgeable about the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs had received training in this area and they understood the key parts of the legislation. They were able to describe how they implemented it in their practice and gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

Patients who needed support form nominated carers were identified on their patient record. However not all the staff we spoke with were aware of who received support from a carer. Where this information was known, clinicians ensured that carers' views were listened to as appropriate. This was supported by the patients we spoke with during the inspection and from the feedback from the representatives of patients who lived in care homes.

Health promotion and prevention

There was a large range of up to date health promotion information available at the practice and on the practice website, with information to promote good physical and mental health, lifestyle choices and self-help. This included information on long term condition management, healthy living, vaccinations and signposted patients to other websites which may be useful. The practice had an information screen in the waiting area, which their phlebotomist had setup to provide specific information to patients.

We saw that new patients were invited into the surgery when they registered. This was designed to find out details of their past medical and family health histories. They were also asked about their lifestyle, medications and offered health screening. The new patient health check was undertaken by a nurse or usually by the health care assistant. 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. The practice offered NHS Health Checks to all its patients aged 40-74 and these

Good

Are services effective?

(for example, treatment is effective)

were undertaken by a nurse or usually the health care assistant. The practice reported that during 2014 to 2015, they had invited 271 patients for a NHS Health Check and 114 had received this check.

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 12 of the 16 patients with a learning disability (75%) had attended for an annual health check in the previous year. There was also a process in place for following up those patients who did not attend for their appointment, which usually involved writing to them by letter. However we were told that the practice were proactive in telephoning patients to remind them of their appointment where this was the most appropriate method. They explained that this was possible as they knew their patients well.

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%), and child health surveillance (100%). They had scored below for the primary prevention of cardiovascular disease (73.1%). They scored the same as the CCG and England average for obesity (100%), contraception (100%) and above the CCG average, but below the England average for smoking (89.9%). The practice told us that these scores were likely to have improved as they now had an effective nursing team in post who were actively undertaking work in these areas. We were told by the practice manager that they were rated the highest in the CCG area and amongst the top 20 practices in England for smoking cessation work. We were shown data that identified that the performance of the practice for smoking cessation in October 2014 was above their target, at 139%. This was above many of the other practices in the CCG area.

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. The uptake of the flu vaccine was above the Clinical Commissioning Group (CCG) average for patients over 65 years old (80.5%), under 65 years old and at risk (54.3%) and children. They were slightly below average for uptake by pregnant women (32.7%).

We saw that chlamydia screening kits were easily available in the patient toilet at the practice. Notices were also on display around the practice advising patients that these were freely available. We were shown data which identified that the practice were amongst the highest performers in the CCG area for the number of patients screened for chlamydia.

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 nine patients and reviewed 37 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. Patients we spoke with told us that they had never heard staff using patient identifiable information whilst they have been waiting in the waiting room.

The reception was located in the waiting room area. 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. One receptionist told us they had used a more private area of the practice to support a patient with dementia who had arrived at the practice the day of our inspection.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015. 247 surveys had been sent out with 111 being returned, which was a response rate of 45%. The survey showed satisfaction rates for patients who thought they were treated with care and concern by the nursing staff (79%) and for whether nurses listened to them, 75% 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 78% and for whether the GP listened to them, 81% reported this as being good or very good. 78% of respondents described their overall experience of the practice as fairly good or very good and 73% 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 72% of practice respondents said the GP involved them in care decisions, 80% felt the GP was good at explaining tests and treatments and 81% said the GP was good at giving them time. These results were average when compared with other practices in the Clinical Commissioning Group (CCG) area. In relation to nurses: 58% said they involved them in care decisions; 74% felt they were good at explaining tests and treatments and 81% said they were good at giving them enough time. The majority of these results were average when compared with other practices in the CCG area.

Patient/carer support to cope emotionally with care and treatment

Information for carers, in the form of leaflets and posters were displayed in the waiting room, and on the practice website. These provided information on a number of

Good

Are services caring?

support groups and organisations that could be accessed for patients, relatives and carers. 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. When a new patient registered at the practice they were asked if they were a carer or had a carer and the practice identified them on the computer system. However this information was not proactively used by all clinicians and some of the clinicians we spoke with were not aware of this. One of the patients we spoke with told us that they had received support from the practice. However, they had to ask for this, rather than it being offered to them as a carer.

Staff told us that if families had suffered bereavement, they were usually sent a letter offering the practice's condolences, In addition to this their usual GP contacted them if this was appropriate. In addition to the support provided by the practice staff, we were told that patients were referred to local external organisations that provided specialist services. We noted that unexpected deaths were discussed at the weekly partners meeting to identify if there was anything that could be learnt or done differently.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice worked collaboratively with other agencies and community health professionals in order to effectively meet patients' needs.

There had been little turnover of staff which enabled good continuity of care and accessibility to appointments with a GP of choice. 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. The appointments system had recently been changed in order to accommodate home visits earlier in the day. This was to ensure maximum time to put support in place for those patients in order to minimise the need for a hospital admission. 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 practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The PPG Annual Report 2014 to 2015 identified priorities for improvement which included a review of the appointment system and to offer early morning and evening appointments, continuity of care and reducing waiting times and improving the website. We saw evidence that improvements had been made to these areas. For example appointments were now available on Tuesday mornings each week from 6.45am to 8am and Wednesday evenings each week from 6.30pm to 7.45pm. We were also told that a cycle rack had been made available for the use of patients following a request for this from patients at the surgery.

Tackling inequity and promoting equality

The practice had an equality and diversity policy. The practice understood and responded to the needs of patients with diverse needs and those from different ethnic backgrounds. Staff told us that translation services were available for patients who did not have English as a first language. Information was available in a non-patient area of the practice about how to access the translation service. However we did not see any notices advising patients that this service was available. Longer appointments were available for patients who needed them, including those who needed an interpreter. There was a self check in screen which could be accessed in different languages, however as this was a new system this had not yet been set up as there had been difficulties with this.

We were shown an example of pictorial guidance which was used for patients to remember when to take their medicines. Different times of the day were depicted and the corresponding number of tablets drawn to represent the number of tablets the patient needed to take at that time. We were also told that patients with visual impairment who needed inhalers were prescribed differently shaped inhalers to enable them to tell the difference between their medicines. We noted that patients were called by clinicians who came to the waiting room. This meant that any patients who needed support were able to receive this.

The practice was situated in a single level building. At the front of the practice there was a ramp to the front door. However the door opened outwards and it was difficult to access for those patients with mobility needs and those who used prams. We spoke with the provider about this. They advised that patients who have difficulty with the front door, know to use the staff entrance at the back where there is a doorbell which alerts staff to assist them. The provider confirmed the day after the inspection that they had put a notice up at the front door to inform all patients and visitors that this alternative means of accessing the practice was available.

The waiting area was 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.

Access to the service

The practice opened every week day between the hours of 08:30am and 6pm, with a lunchtime administrative closure between 1pm to 3pm. The practice duty doctor could be

Good

Are services responsive to people's needs?

(for example, to feedback?)

contacted during this time. Early morning appointments were available Tuesday mornings each week from 6.45am to 8am and Wednesday evenings each week from 6.30pm to 7.45pm. This was particularly useful to patients with work commitments.

Comprehensive information was available to patients about appointments in the practice leaflet and on the practice website. This included how to arrange routine and urgent appointments, telephone consultations and home visits. Appointments could be booked by telephone, in person or online. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed.

We looked at data from the National GP Patient Survey, which was published on 8 January 2015 and found that 75% of patients described their experience of making an appointment as good and 87% 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 ten 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.

We saw that information was available to help patients understand the complaints system, which included contact details for NHS England complaints and escalating complaints to the Parliamentary and Health Service Ombudsman (PHSO). There was information on making a complaint in the practice patient information leaflet, on the practice website and information was on display at the practice. 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.

The practice had received eight complaints from 1 April 2014 to 31 March 2015, five of which were written and three were verbal. We looked at nine complaints which had been received which between 2013 and 2015. These had been acknowledged, investigated and a response had been sent to the complainant. Complaints had been dealt with in a timely way and an apology had been given where this was appropriate. Information was not included in the letter about how to escalate complaints if patients were not satisfied with the outcome, but this information was provided in the complaints policy which could be obtained from reception. Notices were displayed which advised patients of this.

The practice discussed and reviewed complaints at the weekly partners meetings in order to identify areas for improvement. These were shared with the individuals involved in a timely way. The learning identified was then shared at the quarterly practice meetings. The practice had implemented learning from complaints to improve the service offered to patients. For example, reception staff now informed waiting patients of any delays and informed patients of this as they arrived for their appointment. We saw this happen during our inspection.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice manager and the two GP partners told us that they had a vision to provide a patient centred service and were committed to this being caring and safe. They had an up to date statement of purpose that described their objectives, vision and strategy. We spoke with other clinical and non-clinical staff and they all demonstrated these shared values, embraced the principles of providing a patient centred service and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity. These were available in paper copy in the practice. The majority of staff we spoke with knew where to find these policies if required or were able to ask other members of staff, who knew where certain policies were located. We looked at a sample of these policies and procedures and most had been reviewed and were up to date. However we noted that some policies did not have a date for review on them. 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 QOF data for this practice showed it was performing in line with national standards for the majority of areas. The practice was achieving a 93% score (of total available points) which compared with the local Clinical Commissioning Group average of 89.3%. The practice had completed clinical audits which it used to monitor quality and systems to identify where action should be taken. For example we saw the practice had audited the outcomes for patients with chronic obstructive pulmonary disease (COPD) and also audited the use of antibiotic prescribing. (COPD is the name for a collection of lung diseases, including chronic bronchitis and emphysema. Typical symptoms are increasing shortness of breath, persistent cough and frequent chest infections).

The practice had arrangements for identifying, recording and managing risks. We noted that not all risks had been formally assessed and planned for. However where this had not yet happened, we noted these areas had been identified and a plan was in place for them to be undertaken. Any risks identified were discussed both informally with the two GP partners and formally at the weekly partners meeting. The practice had arrangements for identifying, recording and managing significant events and a system for the management of complaints.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control, a clinical lead for diabetes and one of the GP partners was the lead for safeguarding. 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, well supported and knew who to go to in the practice with any concerns.

There were a number of meetings held at the practice in order to share information and provide support for staff. These included separate meetings for groups of staff, including nurses and reception staff. The whole practice team also met quarterly. The practice manager and the two GP partners also met weekly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings with the practice manager, or the GPs. There was a willingness to improve and learn across all the staff we spoke with. The leadership in place at the practice was consistent and fair and as a result of the atmosphere generated, there was low turnover of staff. We were also told that the practice held an event for all staff past and present, to celebrate 20 years of the practice existing on the current site.

Seeking and acting on feedback from patients, public and staff

We found the practice listened and responded in a timely way to formal and informal feedback from patients. Feedback from patients had been obtained through patient surveys, the friends and family test, the patient participation group and complaints. The practice had monitored and assessed some aspects of the quality of its dispensing service.

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

Are services well-led?

Good

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

and family feedback form was easily accessible in the waiting room for patients to complete. We were provided with the following data from the practice. One card had been returned in January 2015, with 100% of patients saying they would recommend, for February, two cards were returned with 50% recommending and 50% providing a neutral response. In March, one card was returned and 100% would recommend. In April, 10 cards had been returned with 100% recommending the practice. The practice had made an effort to encourage patients to completing the friends and family feedback forms and this was evidence in the increase response rate for April.

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 manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. Representatives of the PPG told us they were able to help inform and shape the management of the practice in relation to patient priorities. An example of this was where the PPG had run an open evening on Asthma and another on diabetes. Staff at the practice had supported these events by giving a presentation on these subject areas.

The staff we spoke with described the working environment as caring 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. One member of staff told us they had suggested an improvement to the process for recording patient information for review by a GP which had been 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 in paper copy. 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. Staff confirmed that regular appraisals took place and we were told that these were planned for the nursing staff. We were told that one of the nurses regularly attended external clinical meetings and fed back to the other nurses during their monthly and informal meetings. The practice also closed for staff training for half a day on a quarterly basis.

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 patient surveys 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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Robust processes were not in place to assess the risk of and prevent, detect and control the spread of infection, including those that are health care acquired. The flooring in a clinical room was not appropriate in order to effectively control the spread of infection. Regulation 12 (2) (h).