

Greensands Medical Practice

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?	Good	
Are services effective?	Good	
Are services caring?	Good	
Are services responsive to people's needs?	Good	
Are services well-led?	Good	

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Greensands Medical Practice on 3 May 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.

- The practice had introduced a GP telephone triage system and nurse led minor illness clinics to improve appointment availability.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the duty of candour.

The areas where the provider should make improvement are:

- Develop a centralised system for recording actions taken as a result of safety alerts.
- Continue to develop and adopt procedures for managing blank prescriptions.
- Carry out fire drills on a regular basis.
- Develop systems to ensure policies and procedures are routinely reviewed and updated.

Summary of findings

- Continue to identify and support carers.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- We noted that records relating to actions taken in response to safety alerts were not stored centrally and were on occasion difficult to locate. However, we saw evidence that lessons were shared and action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multi-disciplinary teams to understand and meet the range and complexity of patients' needs. For example, attending regular meetings which followed the gold standard framework for patients requiring end of life care.

Good



Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care. For example, 100% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and the national average of 89%.

Good



Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- We observed a strong patient centred culture.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, the practice offered a range of enhanced services including avoiding unplanned admissions to hospital and minor surgery.
- The practice offered phlebotomy services Mondays to Fridays which was particularly beneficial for their semi-rural population who were not able to access secondary care easily.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Good



Are services well-led?

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. GP partners had lead roles for various clinical and business areas.
- The practice had a number of policies and procedures to govern activity and held regular governance meetings. Whilst policies reflected current requirements and guidance, we noted that not all policies were regularly reviewed and updated.

Good



Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

The practice is rated as good for the care of older people.

- 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, and offered home visits and urgent appointments for those with enhanced needs.
- The practice carried out memory assessments for patients at risk of dementia.
- Annual health checks were available for these patients.
- All these patients had a named GP.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff supported GPs in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the national average. For example, the percentage of patients on the diabetes register, who had received an influenza immunisation in the preceding 12 months was 99% compared to a CCG average of 95% and a national average of 94%.
- Longer appointments and home visits were available when needed.
- The practice ran an anticoagulant clinic for patients to monitor their treatment. (Anticoagulants are medicines used to prevent blood from clotting).
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people.

Good



Summary of findings

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 76% and the national average of 74%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- A consultant gynaecologist provided a monthly in house clinic.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good



The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Telephone consultations were available for those unable to attend the surgery during normal working hours.
- A nurse led telephone results line operated daily to feedback patients' test results, for example following blood tests or X-rays.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients.

Summary of findings

- The practice informed vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- There was a lead GP for mental health.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 91% where the CCG average was 87% and the national average was 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out memory assessments for patients at risk of dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing in line with local and national averages. 237 survey forms were distributed and 132 were returned. This represented a response rate of 56% (1% of the practice's patient list).

- 88% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group (CCG) average of 77% and national average of 73%.
- 76% of patients were able to get an appointment to see or speak to someone the last time they tried which was the same as the national average and comparable to the CCG average of 77%.
- 94% of patients described the overall experience of this GP practice as good compared to the CCG average of 86% and national average of 85%.
- 88% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 80% and national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 52 comment cards which were all positive about the standard of care received. Patients described the standard of care received as excellent and recognised the staff to be caring and respectful. Five comments cards referred to lengthy waits for routine appointments.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. The practice also sought patient feedback by utilising the NHS Friends and Family test. The NHS Friends and Family test (FFT) is an opportunity for patients to provide feedback on the services that provide their care and treatment. Results from October 2015 to March 2016 showed that 90% of patients who had responded were either 'extremely likely' or 'likely' to recommend the practice.

Greensands Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Greensands Medical Practice

Greensands Medical Practice provides a range of primary medical services, including minor surgical procedures from its semi-rural location at Brook End, Potton, Sandy in Bedfordshire. The practice has a branch surgery, known as the Gamlingay Surgery on Stocks Lane, Gamlingay in Cambridgeshire. There is a dispensary at both the main practice and the branch surgery that provides medicine for patients who live more than one mile from a pharmacy.

The practice serves a population of approximately 11,700 patients with higher than average populations of both males and females aged 40 to 74 years. There are lower than average populations of babies and patients aged 15 to 39 years. The practice population is largely white British. National data indicates the area served is less deprived in comparison to England as a whole.

The clinical staff team consists of three female GP partners, four male GP partners, one nurse prescriber, one minor illness nurse, two practice nurses and two health care assistants. The team is supported by a practice manager and a team of administrative staff. The practice holds a General Medical Services (GMS) contract for providing services and is a teaching practice, receiving medical students from the Cambridge University Medical School.

Greensands Medical Practice is open between 8.30am and 12.30pm Mondays to Fridays, and from 2pm to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays. The practice is closed on Thursday afternoons. A GP is available from 8am Mondays to Fridays. The branch surgery in Gamlingay is open from 8.30am to 12.30pm Mondays to Fridays, and from 2pm to 6.30pm on Mondays, Tuesdays, Thursdays and Fridays. The branch surgery is closed on Wednesday afternoons. Patients requiring a GP outside of normal hours are advised to phone the NHS 111 service.

Why we carried out this inspection

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

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 3 May 2016. During our inspection we:

- Spoke with a range of staff including three GP partners, a practice nurse and the practice manager.
- Reviewed policies and procedures in both dispensaries.
- Spoke with patients who used the service at both the main practice and the branch surgery.

Detailed findings

- Observed how staff interacted with patients.
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia).

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

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice discussed significant events as a standing item on the agenda at clinical meetings.
- We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts and patient safety alerts. We noted that records were not stored centrally. However, we saw evidence that lessons learnt were shared and action was taken to improve safety in the practice. For example, we saw that when medicines alerts were received the practice searched for patients affected and ensured that they were contacted where necessary and medication was altered if appropriate. During our inspection the practice assured us that they intended to keep records of actions taken in response to safety alerts in a centrally held file. They also informed us that they planned to discuss safety alerts as a standing item on the agenda at future clinical staff meetings.
- When there were unintended or unexpected safety incidents the practice was prompt to investigate and where necessary improve systems to reduce the risk of recurrence. For example, we saw that when a fridge storing medicines was accidentally unplugged, the practice investigated the incident whilst seeking appropriate advice before destroying the affected medicines. A new power socket specifically for the fridge

was then installed at a higher level to reduce the risk of recurrence. If patients were affected by safety incidents they received reasonable support, an explanation of events and a verbal or written apology if appropriate.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to an appropriate level to manage safeguarding concerns.
- A notice on the television screen in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention team to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, we saw that following an audit the practice had implemented a cleaning schedule for the disposable instrument storage rack.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing,

Are services safe?

recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local medicines management team, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were newly developed systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. She received mentorship and support from the clinical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a

health and safety policy available with a poster in the staff kitchen which identified local health and safety representatives. The practice had up to date fire risk assessments. We noted that the practice had not conducted a fire drill for two years. We were assured that the practice intended to reintroduce a regular schedule of fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. Staff informed us they worked flexibly as a team to cover additional hours during holidays and absence due to sickness.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. Staff also had panic alarm fobs that could be activated to call for assistance.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for suppliers and key stakeholders.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date, including discussion of best practice guidance at monthly clinical meetings. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. For example, we saw that following a review of NICE guidance for the treatment of hypertension the practice introduced protocols for 24 hour blood pressure monitoring to aid diagnosis of hypertension.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 99.5% of the total number of points available, with 7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators was similar to the national average. For example, the percentage of patients on the diabetes register, who had received an influenza immunisation in the preceding 12 months was 99% compared to a CCG average of 95% and a national average of 94%.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 91% where the CCG average was 87% and the national average was 88%. Exception reporting for this indicator was 0% compared to a CCG average of 15% and national average of 13%.

- The percentage of patients with hypertension having regular blood pressure tests was 90% which was better than the CCG and national averages of 84%.

There was evidence of quality improvement including clinical audit.

- There had been 10 clinical audits completed in the last two years, three of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, recent action had resulted in an improvement to the blood taking service for patients dependent on home care. An initial audit had identified that these patients were not receiving blood tests in a timely fashion (with only 77% being processed in the requested timeframe) and that the process for faxing these requests was not working effectively (with only 91% of requests being received). The practice changed the protocol for handling requests and a re-audit of the service showed an improvement to 100% of requests being received and 90% being processed in the requested timeframe.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. We saw that induction programmes were tailored to the specific needs of new staff. Staff we spoke with were able to recall their induction and described it as a valuable process which provided them with structured support and fundamental knowledge when they had commenced their employment.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff; for example, staff reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could

Are services effective?

(for example, treatment is effective)

demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources, attending external training courses and discussion at practice meetings.

- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their computer system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence of regular interactions between community staff (such as the district nursing team, health visitor and midwife) and practice staff.
- We saw that multi-disciplinary team (MDT) meetings took place with other health care professionals on a regular basis when care plans were routinely reviewed and updated for patients with complex needs. For example, the practice held six weekly MDT meetings that made use of the gold standards framework (for palliative care) to discuss all the patients on the palliative care register, update their records accordingly and to formalise care agreements. They liaised with

district nurses, MacMillan Nurses and the community matron. At the time of our inspection there were 34 patients on the palliative care register receiving this care.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example, patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 76% and the national average of 82%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. Data published in March 2015 showed that 65% of patients aged 60-69 years had been screened for bowel cancer in the preceding 30 months, where the CCG average was 60% and the national average was 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 89% to 99% and five year olds from 93% to 100%.

Are services effective? (for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74 years. At the time of our inspection for the period April 2010 to April 2016

the practice had completed 2,181 of 2,745 eligible health checks for the 40 to 74 age group. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 52 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Five comments cards commented on lengthy waiting times when contacting the practice to book routine appointments.

We spoke with one member of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey published January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 100% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 86% and the national average of 89%.
- 95% of patients said the GP gave them enough time compared to the CCG average of 86% and the national average of 87%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and the national average of 95%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84% and national average of 85%.

- 91% of patients said the last nurse they spoke to was good at treating them with care and concern which was the same as the national average and comparable to the CCG average of 92%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and the national average of 87%.

The practice had a stable workforce with many long standing members of staff. We were told that staff and patients were familiar with each other which was beneficial to the practice's aim to provide compassionate care as staff were often able to recognise patients needs and appointment requirements.

We witnessed a strong patient centred culture with a focus on providing continuity of care and excellent service to patients. We saw evidence that the practice was well regarded within the local community and made efforts to support and engage with its local population. For example, the patient participation group (PPG) were planning an awareness week which would incorporate a walk and talk session. This aimed to enable patients to meet their GPs and the practice staff in a less formal environment, encouraging familiarity and helping people in the semi-rural community to build relationships.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey published January 2016 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 95% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and the national average of 86%.
- 91% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 79% and national average of 82%.

Are services caring?

- 85% of patients said the last nurse they saw was good at involving them in decisions about their care which was the same as the national average of 85% and comparable to the CCG average of 86%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.
- Information leaflets were available in easy read format.
- The practice operated a personal list system with GPs maintaining their own patient lists. This ensured that wherever possible patients received continuity of care, providing them with familiarity and confidence in the GPs they saw. Patients we spoke with told us they felt their GPs knew them and that they were encouraged to discuss their treatment options. Patients had the option to request to see a different GP if they wished to.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 64 patients as carers (0.5% of the practice list). The practice recognised this to be a low representation and at the time of our inspection was making efforts to identify carers in their population, for example, by developing a carer's notice board and providing additional information to carers encouraging them to identify themselves to the practice. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice offered a range of enhanced services including avoiding unplanned admissions to hospital and minor surgery. The practice held multi-disciplinary meetings to discuss the needs of palliative care patients and patients with complex needs.

There were registers for patients with dementia and those with a learning disability. These patients were also invited for an annual review and staff informed us that maintaining individual patient lists improved compliance in particular with these patients; as they were more likely to attend reviews with GPs they were familiar with. At the time of our inspection there were 23 patients on the learning disability register who had all received their annual review in the 12 months preceding. There were 46 patients on the dementia register, of which 45 had received annual face to face reviews. The practice carried out memory assessments for patients at risk of dementia. These patients were also able to book longer appointments if needed.

- The practice offered phlebotomy services Mondays to Fridays which was particularly beneficial for their semi-rural population who were not able to access secondary care easily.
- The practice ran an anticoagulant clinic for patients to monitor their treatment. (Anticoagulants are medicines used to prevent blood from clotting). This clinic had been running at the practice for 14 years and was well received by patients as it reduced the need for them to travel to secondary care for the service.
- There was a register of patients from traveller and gypsy communities and the practice made efforts to engage with these patients, in particular those with young children and infants to ensure they were able to access appointments and immunisations as needed.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.

- A consultant gynaecologist provided a monthly in house clinic.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- The practice provided a vasectomy service at its branch surgery.
- There were disabled facilities and translation services available.
- The practice did not have a hearing loop but staff had received deafness awareness training.
- We saw that clinical staff had received training on female genital mutilation and that there was information for patients displayed in the practice.

Access to the service

The practice at Potton was open between 8.30am and 12.30pm Mondays to Fridays, and from 2pm to 6.30pm on Mondays, Tuesdays, Wednesdays and Fridays. The practice was closed on Thursday afternoons. A GP was available from 8am. The branch surgery in Gamlingay was open from 8.30am to 12.30pm Mondays to Fridays, and from 2pm to 6.30pm on Mondays, Tuesdays, Thursdays and Fridays. The branch surgery was closed on Wednesday afternoons. Patients requiring a GP outside of normal hours are advised to phone the NHS 111 service. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey published January 2016 showed that patient's satisfaction with how they could access care and treatment was variable in comparison to local and national averages.

- 65% of patients were satisfied with the practice's opening hours compared to the CCG average of 79% and national average of 78%.
- 88% of patients said they could get through easily to the practice by phone compared to the CCG average of 77% and national average of 73%.

The practice was aware of lower satisfaction scores for practice opening hours and had amended their services accordingly. The practice had previously offered extended hours but found they were not utilised by patients. They were aware that demand for appointments was high and had introduced minor illness clinics with nurses to ensure patients had increased access to appointments. They had also introduced a GP triage system ensuring that patients

Are services responsive to people's needs?

(for example, to feedback?)

requesting urgent appointments were able to speak to a GP to assess their clinical need and book appointments accordingly. A nurse led telephone results line operated daily, providing feedback on test results to patients, for example following X-rays or blood tests. Staff told us this service had been well received by patients and that patients requiring urgent care were always seen the same day. We were told of plans to continue training nurses and health care assistants to expand their roles and expertise in an effort to alleviate pressures on GP appointments.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

For example, by speaking to the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

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

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the waiting room, at reception and on the practice website.

We looked at 13 complaints received in the last 12 months and found that the practice handled them objectively and in an open and timely manner. Lessons were learnt from individual concerns and complaints and actions were taken as a result to improve the quality of care. For example, we saw that when a patient complained about the treatment of a relative, the practice were prompt to investigate and discussed the complaint at a clinical meeting with external health care providers, before responding to the patient. Practice protocols were amended to improve outcomes for patients and reduce the risk of recurrence.

Are services well-led?

Good 

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the staff areas and staff knew and understood the values. The mission statement was developed by the practice team and used the acronym PRIDE; representing professionalism, respect, integrity, dedication and excellence.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff in the practice manager's office. Whilst policies reflected current requirements and guidance, we noted that not all policies were regularly reviewed and updated.
- A comprehensive understanding of the performance of the practice was maintained. In particular, GP partners were responsible for monitoring specific areas of the Quality and Outcomes Framework (QOF) which enabled the practice to track QOF performance meticulously.
- There was a programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, an explanation of events and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- There were lead GPs for various clinical and business roles; for example safeguarding, mental health, finance, personnel, palliative care and unplanned admissions.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held quarterly. We were told of regular social events held to maintain good relations between staff.
- Staff said they felt respected, valued and supported, particularly by the partners and managers in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly and submitted proposals for improvements to the practice management team. For example, we saw

Are services well-led?

Good 

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

that the PPG had organised a patient participation awareness week at the practice. This planned to encompass a walk and talk session for patients to meet with practice staff and learn about services available and upcoming changes at the practice.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local plans to improve outcomes for patients in the area. We were told that the practice was working closely with other practices in the locality to bid for funding to develop a locally accessible hub. If successful, this hub would house various outreach clinics, such as a community Geriatrician, bringing services normally found in secondary care services closer to the semi-rural population.

We saw evidence of a robust programme of audit that had run historically in the practice to monitor performance, implement change and ensure patients achieved the best outcome where possible. The practice provided support to a cohort of medical students from the Cambridge University Medical School. In addition we were told of plans for a GP partner to qualify as a trainer enabling the practice to become a training practice for qualified doctors wishing to train as GPs.

The practice was keen to improve access to appointments, whilst continuing to reduce patient attendance at local accident and emergency departments. We saw plans to upskill existing staff, in particular health care assistants and nurses, to alleviate pressures on GP appointments. For example, through the provision of additional nurse led minor illness clinics and the extension of the GP telephone triage system to incorporate nurse telephone triage. There was a commitment to training and developing staff to equip them with additional skills needed to enable the practice to achieve this goal.