

Orton Bushfield Medical Centre

Quality Report

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

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 Orton Bushfield Medical Centre on 8 March 2016.

Overall the practice is rated as good.

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

- Patients spoke highly of the staff and told us they were treated in an empathetic, caring and respectful way. However, some raised concerns about the availability of appointments and difficulty in accessing the practice by telephone.
- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).

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

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The provider was aware of and complied with the requirements of the Duty of Candour.

There were areas where the provider could make improvements and should

- Ensure that medicines held in the doctor's home visit bag are checked regularly.
- Improve the training for reception and administrative staff to ensure they have appropriate knowledge and skills for their role.

Summary of findings

- Continue to improve the uptake of cervical screening for patients.
- Improve the recording and monitoring of patients' complaints.

We had identified a number of shortfalls at our previous inspection in June 2015 and issued two requirement notices as a result. During this inspection, we found that the practice had taken sufficient action to address the breaches in regulations. Serious incidents were analysed

more closely; staff recruitment procedures were more robust; the number of patients with learning disabilities who had received an annual health check had substantially increased, and prescription security had strengthened.

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 and lessons were shared to make sure action was taken to improve safety in the practice. The practice's safeguarding procedures were good and

ensured that patients were protected. Procedures in place to deal with emergencies and major incidents and risks to patients were assessed and well managed.

Good



Are services effective?

The practice is rated as good for providing effective services. Staff had the skills, knowledge and experience for their role. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff worked closely with a range of health and social care colleagues to ensure patients' needs were met. The practice had significantly improved the number of patients with a learning disability who had received an annual health check. The practice's QOF scores for 2014/2015 for diabetes indicators and cervical screening rates were below national averages. However, the practice were being pro-active in addressing these, and more recent figures showed improved results.

Good



Are services caring?

The practice is rated as good for providing caring services. Patients said they were treated in a way that they liked and that staff were empathetic to their needs. National data showed that patients rated the practice's nurses higher than others for several aspects of care including treating them with care and concern, and being good at listening to them. We found that staff treated patients with kindness and respect, and maintained their confidentiality. The deputy manager actively supported a number of vulnerable clients with non-clinical matters.

Good



Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It 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. Although the building was old, the practice had good facilities and was well equipped to treat patients and meet their needs. It responded well to suggestions from its patient participation group

Good



Summary of findings

and worked hard to implement them where possible. Urgent appointments were available same day. Patients told us that access to the practice by telephone was poor, however four additional lines were being installed as part of the forthcoming refurbishment.

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. There was a clear leadership structure in the practice and staff felt supported by management. Staff had defined roles and responsibilities within the practice and were supported to maintain their professional development. Staff had regular performance reviews and attended staff meetings. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.

Good



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 and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered same day telephone triage for all urgent requests to patients over 65.

The practice offered vaccination against influenza, pneumococcus and shingles. Home visits for vaccinations were arranged for older patients who were housebound.

Good



People with long term conditions

The practice is rated as good for the care of people with long-term conditions. Clinical staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had structured annual reviews to check that their health and medication needs were being met. Fortnightly multi-disciplinary meetings were held to discuss the complex needs of patients in this group and these patients had pro-active care plans in place.

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. Six week postnatal reviews were routinely offered to mothers and babies. Antenatal clinics were run at the practice by the local midwife, and health visitors also saw patients there if needed. Same day appointments were available to all children under 5 years of age. Monthly multidisciplinary meetings were held with health visitors to discuss any children at risk. Immunisation rates were relatively high for all standard childhood immunisations, apart from the meningitis C vaccine.

Good



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. On-line services were available for booking appointments and managing repeat prescriptions, and telephone consultation was available between 12 and 1pm each

Good



Summary of findings

day. Extended hours opening were available on a Monday evening for those who found it hard to attend during working hours. The practice offered routine screening services such as cervical smears, NHS health checks and well person clinics.

People whose circumstances may make them vulnerable

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing and documentation of safeguarding concerns. The practice used a system of placing alerts on patients' records to highlight if they were carers so they could be identified for additional support if required. The practice offered longer appointments for patients with a learning disability and had greatly increased the number of these patients who had received an annual health check since our last visit.

Good



People experiencing poor mental health (including people with dementia)

The practice maintained a register of patients with dementia and participated in the dementia identification scheme enhanced service. 78% of patients diagnosed with dementia had received a face to face care review in the last 12 months, which was comparable to the national average of 84%.

Practice nurses were able to administer injections prescribed by psychiatrists, and a specific member of staff oversaw the weekly prescriptions to those at risk of poor mental health. 92% of patients experiencing poor mental health had received an annual health review to ensure appropriate treatment and support was in place. Counselling services held sessions at the practice each week and patients could either be referred by their GP or make a self-referral. Staff regularly referred patients experiencing poor mental health to various support groups and voluntary organisations, including Aspire and Drinksense.

Good



Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016. The results showed the practice were sometimes below local and national averages. 287 survey forms were distributed and 106 were returned.

- 73% of patients were satisfied with the practice's opening hours compared to the national average of 78%.
- 77% of patients said the GP was good or very good at involving them in decisions about their care compared to the national average of 82%.
 - 47% found it easy to get through to this surgery by phone compared to national average of 73%.
 - 67% described the overall experience of their GP surgery as fairly good or very good compared to the national average of 85%.

- 23% of patients said they always or almost always see or speak to the GP they prefer compared to the national average of 36%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 41 comment cards. The majority of respondents praised the skill, professionalism and empathy of the practice's staff. However, 12 patients described difficulties in getting an appointment, and four patients told us they often had to wait a long time to be seen once arriving at the practice. Two people felt the building was old and in need of refurbishment.

Areas for improvement

Action the service **SHOULD** take to improve

- Ensure that medicines held in the doctor's home visit bag are checked regularly
- Improve the training for reception and administrative staff to ensure they have appropriate knowledge and skills for their role.

- Continue to improve the uptake of cervical screening for patients.
- Improve the recording and monitoring of patients' complaints.

Orton Bushfield Medical Centre

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 adviser and a practice manager specialist adviser.

Background to Orton Bushfield Medical Centre

Orton Bushfield Medical Centre is located in the NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area and is contracted to provide general medical services to approximately 5497 registered patients. The practice covers a large urban area including Alwalton, Hampton, New Fletton, Orton Northgate, Orton Wistow and Woodston. The practice is centrally located and has a chemist close by.

The practice has two GP partners who hold overall financial and managerial responsibility for the practice, and a part-time salaried GP. Also employed are two nurses and a health care assistant. They are supported by a practice and deputy manager, two medical secretaries and six reception/administrative staff. The practice is also a training centre for Cambridge University students.

According to Public Health England information, the patient population has a slightly higher than average number of patients aged 0 to 29 years, and a lower than average number of patients aged 70 to 85 plus years compared to the practice average across England.

The practice is open between 8.30am and 1pm, and 1.30pm- 6pm Monday to Friday. Appointments are available from 8.30am to 12pm, and 3.30pm to 6pm Monday to Friday. Extended hours surgeries are offered on Monday evenings from 6.30pm to 7.15pm. In addition to this, patients registered at the surgery are able to access evening and weekend appointments at another local surgery as part of the Prime Minister's Challenge Fund. Outside of practice opening hours, a service is provided by calling NHS 111. The out of hours' service for minor illness & injury unit is available to all patients who need emergency treatment when the surgery is closed.

We inspected the practice in June 2015 and found that the practice was in breach of two regulations as its recruitment procedures were not robust, and the number of patients with a learning disability who had received an annual health check was very low. We issued two requirement notices as a result.

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.

We also undertook the inspection to check that the provider had implemented sufficient improvements to meet the regulations since we last inspected in June 2015.

Detailed findings

How we carried out this inspection

Before visiting, 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 visit on 8 March 2016. During our visit we:

- Spoke with a range of staff including two GPs, two nurses and two reception staff. We spoke with four patients who used the service.
- Reviewed an anonymised sample of 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

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. Staff told us they reported incidents to the practice or deputy manager who then oversaw the management of them. We viewed minutes of a practice meeting held on 3 March 2016 involving all staff, where significant events regarding a missing laboratory sample and a child being prescribed the wrong dose of medication by the hospital had been discussed. Staff we spoke with were aware of these incidents and were able to download the reports of them for us. Staff told us they felt confident and encouraged to report incidents. The monitoring and analysis of significant events had improved since our previous visit; now each event was assigned a specific category such as 'clinical' or 'medicines' to help the practice identify any common themes or patterns to the events.

National patient safety and medicines alerts were actioned by the practice manager or her deputy. They were put on the practice's shared computer drive for access and hard copies given to all relevant clinicians. The GPs we spoke with confirmed the system in place and displayed knowledge of recent alerts that they had responded to. For example, one recent alert related to the use of the medicine Mirabegron and we saw that all patients on this drug had been reviewed and their treatment changed if needed.

Overview of safety systems and processes

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. Staff were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies involved in protecting people. Contact details of organisations involved in protecting people were easily accessible for staff in the reception area. Safeguarding information was disseminated at weekly practice meetings, or via notification tasks.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. All staff we

spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. One nurse gave us a specific example of where she had reported safeguarding concerns for a child appropriately. We noted that the safeguarding issue of female genital mutilation had been discussed at a recent practice meeting on 3 March 2016 to ensure all staff were aware of their responsibility to report any incidents.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. Any incident where a child did not attend a hospital or immunisation appointment was automatically dealt with as a safeguarding concern and followed up by staff. Monthly multidisciplinary safeguarding meetings were held to discuss children and adult safeguarding matters.

There was a chaperone policy, which was visible in the waiting room noticeboard (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). At our previous inspection in June 2015, we found that some reception staff undertook chaperone duties without proper training or 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. At the time of this inspection only nurses undertook chaperone duties. However, the practice had trained three to four reception staff in chaperoning and was undertaking enhanced DBS checks for all its staff to ensure they were suitable to work with vulnerable patients.

Cleanliness and infection control

Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Notices about hand hygiene techniques were displayed in staff and patient toilets. Curtains in consultation rooms were disposable and were changed regularly. Spillage kits were available in each treatment room to manage any spillage of bodily fluids.

Cleaning was undertaken by a private contractor and we viewed audits it undertook to ensure the premises were cleaned to a good standard.

Are services safe?

One of the practice's nurses was the lead for infection control and showed a good knowledge of infection control procedures and undertook regular audits of the premises. The last audit had been completed in February 2016 and had identified a tear in one of the treatment couches. A new one had been ordered as a result.

We observed the premises to be mostly clean and tidy. This included the consultation rooms, the reception and waiting area and the toilet facilities. However we noted that tiles were cracked and the sealant was worn away around one sink in a treatment room making the area difficult to clean. This room was also carpeted, and the carpet was heavily stained and marked. The registered manager assured us these issues would be resolved as part of the practice's forthcoming refurbishment.

Medicines Management

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The practice's prescribing rates for 2014 to 2015 were broadly comparable to national figures. For example, the number of antibacterial prescription items issued was 0.36%, compared to a national average of 0.27%. The number of non-steroidal anti-inflammatory drugs items prescribed was 85%, compared to a national average of 77%. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing.

The practice monitored repeat prescribing for patients receiving medication for mental ill-health or addiction. A specific member of staff dealt with weekly prescriptions for these patients, so that any deterioration in their health or risks could be picked up quickly. We checked records for patients prescribed levothyroxine, methotrexate and lithium. We found that patients prescribed lithium and levothyroxine were receiving regular blood tests and medication reviews in line with guidance. However one of 17 patients had not received a medication review for their methotrexate. However they had received regular blood testing.

We checked medicines in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. Processes were in place to check medicines were within their expiry date and suitable for use. However we found out of date aspirin, penicillin and prednisolone in the doctor's home visit bag which meant that these checks were not being undertaken robustly. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

All prescriptions were reviewed and signed by a GP before they were given to the patient and staff rang patients up if they failed to collect their prescription. At our previous inspection we found that prescription pad security did not meet national guidance. During this inspection we noted improvements: the deputy practice manager now kept all blank prescriptions locked in her office and maintained a log so that each prescription could be tracked through the practice.

The nurses used Patient Group Directions to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines.

Staff recruitment

At our previous inspection in June 2015, we found that the practice did not have any policies and procedures in place for guidance about the recruitment of new staff, and that appropriate recruitment checks had not been undertaken for some staff. There was also no record of new staff having received an induction. During this inspection we found that the practice had implemented a specific recruitment policy which we viewed, and had also formalised its induction procedures. We checked the recruitment files for two staff that had been employed since our last inspection and found that appropriate recruitment checks had been undertaken prior to their employment including references, qualifications, proof of their identification the appropriate checks through the Disclosure and Barring Service. We also found evidence that staff had completed an induction to their role. The practice was in the process of updating enhanced DBS checks for all its staff, even those who had worked at the practice for many years.

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

Are services safe?

safety policy available with a poster which identified local health and safety representatives. The practice had up to date fire risk assessments a variety of other risk assessments in place to monitor safety of the premises. An external contractor visited regularly to conduct a range of health and safety checks including water, fire alarm testing and emergency lighting.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator which were within their expiry date. Fire alarms were checked regularly. At our previous

inspection we noted that staff had not undertaken regular fire drills to practice how they would respond in the event of a fire. During this inspection we found that a full fire evacuation drill had been completed in December 2015.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The box of emergency medicines was replaced every six months by a local pharmacy to ensure that stock was kept in date. However we found that a number of medicines in the doctor's home visit bag were out of date.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice, copies of which were kept off site by the GPs. Risks identified included power failure, loss of the telephone system, industrial action and loss of key staff. The document contained relevant contact details for staff to refer to. For example, there were contact details of gas, water, electricity and burglar alarm suppliers should these fail. The plan had been reviewed regularly to ensure it was up to date and relevant.

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. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. The GPs frequently used computer generated templates to ensure that the treatment provided was comprehensive, standardised and took into account best practice guidance. We found evidence of this on the patients' records we reviewed.

The GPs led in specialist clinical areas such as heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The management of patients' long-term conditions was mostly undertaken by the practice's nurses, supported with advice from the GPs if needed. All patients with long term conditions were on a recall list which was managed by the deputy practice manager each month. The nurses held a number of clinics including those for immunisations, asthma, chronic obstructive airways disease and diabetes. Patients were invited to have all the relevant tests for the monitoring of their long term condition. If they did not attend, they were re-invited or telephoned directly by staff.

There were proactive care plans in place for patients with long term conditions and complex needs and fortnightly multidisciplinary meetings were held to ensure they received appropriate care. We saw that after these patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. The practice also maintained an end of life register and held a monthly meeting with the palliative care Macmillan nurse to discuss those patients on this register. Dementia screening was undertaken for those patients identified at risk.

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 showed that the practice had achieved 88.7% of the total number of points available, with 10.6 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). Data from 2014/2015 showed mixed results for the practice;

- Performance for rheumatoid arthritis related indicators was 100%, which was 5.5 percentage points above the CCG average and 4.6 percentage points above the national average.
- Performance for heart failure related indicators was 100%, which was 4.2 percentage points above the CCG average and 2.1 percentage points above the national average.
- Performance for diabetes related indicators was 75.8%, which was 13.7 percentage points below the CCG and 13.4 percentage points below national average. However, the practice was aware of performance in this area which had been caused primarily by a temporary reduction in nursing staff. We were provided with more recent figures by the practice which showed marked improvement for these indicators. For example, blood pressure monitoring had risen from 58% in 2014/2015, to 82.6% at the time of our inspection.
- Performance for COPD related indicators was 84%, which was 12.% below CCG average, and 12% below national average. However the practice had dedicated specific nurse time for COPD management which had improved performance. For example, the percentage of patients who had received a review of their breathlessness had increased from 75% in 2014/2015, to 97% at the time of our inspection.

The practice had also improved its performance in some mental health indicators as a result of specifically targeting these patients. As a result the percentage of patients with serious mental problems whose alcohol consumption had been recorded in the last 12 months had risen from 63% in 2014/2015 to 68% at the time of our inspection.

The practice showed us three clinical audits that had been undertaken in the last year. Two of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, one

Are services effective?

(for example, treatment is effective)

audit was undertaken to review the prescribing of all drugs for urinary frequency to ensure it was safe and complied with local and national guidance. As a result, the management of patients with urinary incontinence had improved. One of the nurses had undertaken an audit in relation the practice's antimicrobial prescribing. The audit had demonstrated that antibiotics were being prescribed in line with the CCG guidance. However, a further audit was planned to breakdown the results for each prescribing clinician within the practice.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The practice also reviewed information from local hospitals, out of hours services and outpatients departments to identify patients who attended regularly, and might need to have their own personalised care plans.

All patient referrals were reviewed by another GP to ensure their quality, appropriateness and that alternate pathways had been considered by the clinician. In addition to this, all patient referrals were reviewed by clinicians quarterly to monitor their outcome.

Effective staffing

Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. Two new receptionists and a secretary had been employed to deal with the practice's increasing work load, as well as two new prescription clerks to help the practice better manage its medicines.

Staff told us there were enough of them to maintain the safe running of the practice and to cover each other's sickness or annual leave. The deputy practice manager was available to offer additional support at busy times and could cover staff shortages when needed. One doctor had recently retired and the practice had employed a locum GP to cover. This locum GP was in the process of joining the practice as a new partner. Both nurses we interviewed raised concern about their heavy workloads. However the practice had recently been part of a successful bid for the funding of an additional chronic disease management nurse and was in the process of recruiting them.

We found staff to be knowledgeable and experienced for their roles. Reception and administrative staff were multi-skilled and able to provide cover for one another when required. There was a member of staff who was

responsible for clinical coding, and had received training for this role. The practice employed a former nurse on an ad-hoc basis to undertake the summarising of patients' notes. Nurse training records we viewed demonstrated that they had undertaken a range of training relevant for their role and they also attended regular study days to keep their skills and knowledge up to date. One nurse told us she had recently undertaken a level 5 course in minor illness triage, and another had recently attended training in spirometry. However training for administrative staff was limited and they only undertook basic mandatory training. None had received training in areas such as information governance, dementia awareness, or customer care skills.

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 intranet system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. 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 services 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 that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

The practice participated in a number of local admission avoidance schemes and emergency hospital admission rates for the practice were similar at 19% compared to the national average of 15 %. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

Are services effective?

(for example, treatment is effective)

The practice held regular multidisciplinary team meetings with a range of health and social care professionals to discuss patients with complex needs, and those at the end of their life. Decisions about care planning were documented in a shared care record.

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. Staff were also aware of the Gillick competency, and one nurse told us that the practice's computer system had a specific template which prompted her to ask questions about young patients' ability to understand and make their own decisions about their treatment which she found useful. Nursing staff administering vaccinations to children were careful to ensure that the person attending with a child was either the parent or guardian and had the legal capacity to consent. We viewed a poster on the nurse's treatment room door, reminding patients that only those with parental responsibility could consent to children being immunised.

Supporting patients to live healthier lives

All new patients registering with the practice were offered a health check. This included checks of their height, weight and blood pressure. The practice also provided NHS Health Checks to its patients aged 40 to 74 years. The practice had a 15% uptake of health check for eligible patients which exceeded the Cambridgeshire and Peterborough CCG's rate of 12%. 92% of patients with severe mental health problems had received an annual physical health check.

At our previous inspection of June 2015 we found that only 5% of people with a learning disability had received an annual health check. This was a very low rate and we issued a requirement notice as a result. Since our last inspection the practice had liaised with the local learning disabilities team to update their list of patients with learning disabilities and had also undertaken additional training. The health checks were now planned each month in advance and the deputy practice manager rang the patient every month to remind them. Latest figures showed a marked improvement with 58% of patients now having received a check.

The practice's performance for the cervical screening programme was 72%, which was below the national average of 82%. The practice was very aware of this significant variation and had implemented a number of measures to increase the take up, including sending two text message reminders and then an additional letter to encourage patients to attend. This had increased performance. One of the GPs told us that, as a rule, staff were reluctant to exception report patients who did not attend for their cervical screening. The practice's exception report rating for these patients was low at 3.5%, compared to a CCG average of 7.9% and a national average of 6.3%.

The practice offered a full range of immunisations for children and travel vaccines in line with current national guidance. Last year's performance was similar for the majority of immunisations where comparative data was available. There was a range of useful leaflets and posters in the waiting areas giving patients information on a range of health matters. Patients were encouraged to access the smoking cessation service provided on site by the Healthy Living Team.

Are services caring?

Our findings

Kindness, dignity, respect and compassion

All of the 41 patient Care Quality Commission comment cards we received were positive about the practice's staff. Patients described staff as empathetic, respectful and caring and that they were treated in a way that they liked. The deputy practice manager regularly contacted particularly vulnerable patients to check on their welfare and to offer assistance with any non-clinical matters.

Throughout our visit we noted that consulting and treatment room doors were kept shut to ensure people's privacy during their appointment. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. However, 60% of the patients who had completed the PPG's survey were concerned about the lack of privacy when speaking to reception staff. In response to this, a barrier had been introduced to allow only one patient at a time to approach the reception desk. This reduced the risk of patients overhearing potentially private conversations and we saw this in operation during our inspection. We noted that clinical staff collected patients in person from the waiting areas when their appointment was due. This had replaced an unpopular ticketing system that had operated previously.

Results from the national GP patient survey published in January 2016 showed that the practice was broadly comparable to national averages for its satisfaction scores on consultations with GPs and nurse. For example:

- 87% said the GP was good at listening to them compared to the CCG average of 89% and national average of 89%.
- 81% said the GP gave them enough time (CCG average 87%, national average 87%).
- 96% said they had confidence and trust in the last GP they saw (CCG average 96%, national average 95%).
- 79% said the last GP they spoke to was good at treating them with care and concern (CCG average 85, national average 85%).

- 89.7% of patients said the nurse was good or very good at treating them with care and concern (CCG average 90.6%, national average 90.6%).
- 80% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%)

Care planning and involvement in decisions about care and treatment

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

- 84% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 97% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 90%.
- 77% said the last GP they saw was good at involving them in decisions about their care (CCG average 82% , national average 82%).
- 78.5% of patients said the nurse was good at involving them in decisions about their care (CCG average 85.3%, national average 85.1%).

Staff told us that translation services were available for patients who did not have English as a first language and that these were used frequently.

Patient and carer support to cope emotionally with care and treatment

Staff we spoke with had a good knowledge of a range of local support agencies, and referred patients to them when needed. Counselling services were available on site, including Improved Access to Alternative Psychological Therapies (IAPT) IAPT where patients could self-refer. There was a wide range of leaflets and posters in the practice's waiting room, giving patients good information about local support and advocacy groups that they could contact for additional support.

The practice's computer system alerted GPs if a patient was also a carer and the practice had identified 44 patients with caring responsibilities. The practice took part in the Carers' Prescription Service. When GPs identified patients in their practice who provided care to others, they could write a

Are services caring?

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. There was a specific noticeboard for carers in the patients waiting area, giving information about local groups and support.

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. The practice manager regularly attended local CCG meetings and engaged in CCG initiatives. For example, the Peterborough area had been selected as a Prime Minister's Challenge fund area and the practice were involved in the implementation of a service to deliver extra appointments between 8am and 8pm. It also participated in a number local initiatives to increase access to healthcare for older patients.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. For example, reception telephones had been re-sited to improve privacy; an on-line appointment booking system had been implemented to improve access to appointments, and a barrier had been introduced to the main reception desk to give patients more privacy.

The practice's chronic disease nurses undertook home visits for patients' medical reviews if needed and home visits were available for older patients and patients who might benefit from these. Same day appointments were available for all children under 5 years of age, and those with serious medical conditions.

Translation services were available and the practice's website had an automatic translation facility which meant that patients who had difficulty understanding or speaking English could gain 'one-click' access to information about the practice and about NHS primary medical care.

The practice was centrally located and there was a chemist close by. It was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. A designated disabled parking bay was adjacent to the rear surgery entrance. There was a large waiting area with plenty of space for wheelchairs and prams.

Electronic prescription services were available which gave patients flexibility and choice about where to collect their

medicines. Patients were able to receive travel vaccinations available on the NHS. There were a number of other health and care services sited in the building including podiatry, physiotherapy, speech and language therapy and smoking cessation, allowing easy access for the practice's patients.

Access to the service

Comprehensive information was available to patients about appointments on the practice's website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. The practice was open from 8.30am to 6pm Monday to Friday and appointments were available from 8.30 am to 12pm, and 3.30pm to 6pm. Telephone consultations were available between 12 and 1pm. Extended surgeries were offered on Monday evenings until 7.15 pm for patients who found it difficult to attend during normal opening hours. Patients registered at the surgery were able to access evening and weekend appointments at another local surgery as part of the Prime Minister's Challenge Fund.

Routine appointments could be made by telephoning the surgery, by calling in or on-line. On the day appointments could be booked by patients at 8.30 am and again at 2.30pm. The practice had introduced a telephone triage system to improve the management of urgent requests for same day appointments.

However, some results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was low compared to local and national averages.

- 47.1% of patients said they could get through easily to the surgery by phone, compared to the national average 73.3%.
- 63% of patients said the last time they wanted to see or speak to a GP or nurse they were able to get an appointment, compared to a national average 77%.
- 22.6% of patients said they always or almost always see or speak to the GP they prefer (compared to the national average 36.2%).

Of the 41 comment cards we received from patients, 12 specifically mentioned difficulty of access by telephone, and delays with getting an appointment at a suitable time. Four patients commented on the length of time they had to wait having arrived for their appointment. The practice was well aware of the difficulty with patient telephone access as

Are services responsive to people's needs?

(for example, to feedback?)

it only had two access lines which were split between all the services using the building. However a new telephone phone system was planned as part of the refurbishment of the building, giving the practice an additional four lines.

Listening and learning from concerns and complaints

Information about raising concerns was detailed in the practice's patient information leaflet which was given to all new patients when they registered, and on its website. At our previous inspection we noted that there was no information in the waiting area informing patients how they could raise their concerns. During this inspection we saw that complaints leaflets were on display on the reception desk. The procedure was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We viewed the paperwork in relation to three formal complaints the practice had received since our previous inspection in June 2015. However, recording of the complaints was poor and we could not tell whether or not the complaints had been investigated within timescale, or what the outcome and learning from them had been. It was not clear if patients had been given details of other agencies the patient could contact if a patient was not satisfied with the outcome of the practice investigation into their complaint (e.g. Clinical Commissioning Group, NHS England and/or The Parliamentary and Health Service Ombudsman). This was something we raised at our previous 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 had a clear set of guiding principles which were used to inform how it operated. These included providing a safe, caring and high quality service to patients, to work with other healthcare organisations in the best interests of patients, and to foster a culture of learning. Staff were well aware of the challenges the practice faced, including the limitations of the building, its outdated telephone system and the need to improve its administrative systems. The practice had been pro-active in responding to these challenges and, after a period of considerable turmoil, reported it was now in a much better position to plan and build for the future. The long awaited refurbishment of the building had just started, and work had already begun on site.

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 leadership structure with named members of both clinical and administration staff in lead roles. 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
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Communication across the practice was structured around key scheduled meetings. The partners and practice managers met weekly to discuss any clinical, staffing or business matters. Non-clinical staff met regularly to discuss a range of administrative matters such as appointments, scripts and information management, and quarterly whole team meetings were held to discuss issues affecting the practice and undertake joint training.

The practice regularly completed an information governance tool to ensure it managed patients' information in line with legal requirements.

Leadership and culture

There was a clear leadership structure in place and staff we spoke with clearly enjoyed their job and were enthusiastic about their work. Staff told us the practice held regular team meetings and they had the opportunity to raise any issues at team meetings and felt confident in doing so.

The practice was aware of and complied with the requirements of the Duty of Candour and we noted that this had been discussed at a recent practice meeting to ensure that all staff were aware of their obligations.

We identified a number of shortfalls at our previous inspection in June 2015. We found that the practice had taken sufficient action to address these and meet the breaches in regulations. For example, serious incidents were analysed more closely; staff recruitment procedures were more robust; the number of patients with learning disabilities who had received an annual health check had substantially increased, and prescription security had strengthened.

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

The practice had an active patient participation group (PPG). A PPG noticeboard was prominently displayed in the waiting area which explained the role of the PPG and gave details of the times and dates of forthcoming meetings. The PPG met monthly with representatives from the practice and had supported them with providing patient feedback. The PPG facilitated an annual patient survey and we saw that the practice had implemented a number of measures to address patients' concerns in relation to privacy at reception and access to appointments.

We spoke with the chair of the PPG, who was passionate about the practice and proactive in supporting practice staff to achieve good outcomes for patients. She reported that the suggestions made by the PPG to improve the service were listened to and acted upon by the practice. For example, the PPG had suggested that pre-bookable on-line appointment should only be available two weeks in advance, rather than a month, to reduce the number of missed appointments by patients. This had been implemented and PPG members monitored the on-line

Are services well-led?

Good 

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

booking system and rang the deputy practice manager to report any concerns. The PPG had also suggested that the number of missed appointments was displayed in the waiting area to make patients aware of the amount of time wasted: the practice had agreed to do this. The PPG chair also told us that members had been actively involved in, and consulted about, the practice's forthcoming refurbishment and had been invited to attend meetings with the builders.

The practice had begun to collate feedback from patients from the 'friends and family' test, which asks patients, 'Would you recommend this service to friends and family?'

The friends and family feedback form was accessible in the waiting room for patients to complete and could also be completed via the practice's web site, although completion rates were low.

The practice also gathered feedback from staff through practice meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Their suggestions were listened to, and one nurse reported that she had clarified the deep vein thrombosis pathway for clinicians, and a poster of the pathway was now available in each treatment room.