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	**Requires improvement**
Are services safe?	**Requires improvement**
Are services effective?	**Requires improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Good**
Are services well-led?	**Good**

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Orton Bushfield Medical Centre on 9 June 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice to be good for providing caring, responsive care, and a well service. It required improvement for providing safe and effective care.

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

- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles.
- The practice showed it had improved the way it managed some of the most common chronic diseases such as diabetes, coronary heart disease and chronic obstructive pulmonary disease in the last year.
- Patients said they were treated well by staff and that they were involved in their care and decisions about their treatment.
- Information was provided to help patients understand the care available to them.
- 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.
- Recruitment procedures were not robust and essential pre-employment checks had not been completed for some staff.
- Cervical screening rates were low, as were the take up of annual health checks for people with learning disabilities.
- Governance procedures needed to be strengthened to ensure the service was effectively monitored and risks identified.

Summary of findings

There were areas of practice where the provider needs to make improvements

Importantly the provider must:

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Risk assess the need for staff members to be subject to a criminal records check. This includes staff who undertake chaperoning duties.
- Proactively support people with learning difficulties to attend annual physical health checks.

Importantly the provider should :

- Improve the way patients' complaints are managed and ensure there is information easily available about how to complain.
- Improve the security and management of blank prescription forms.
- Improve the take up of cervical screening
- Ensure robust governance arrangements are in place to assess and monitor the quality of services provided.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. The practice's safeguarding procedures were good and ensured that patients were protected. High risk medicines were managed well and there were procedures in place to deal with emergencies and major incidents. However, recruitment procedures were not robust and key employment checks were not undertaken before staff started to work at the practice. Improvement was needed to ensure that significant events were effectively monitored over time.

Are services effective?

Requires improvement

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. However the number of people with a learning disability who received a annual health check was low, as were cervical screening rates.

Are services caring?

Good

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 saw that staff treated patients with kindness and respect, and maintained their confidentiality. We were given specific examples of when staff had gone the extra mile for patients such as delivering prescriptions to them, or making calls to check on their welfare.

Are services responsive to people's needs?

Good

The practice is rated as requires improvement 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. It responded well to suggestions from its patient participation group and worked hard to implement them where possible. Urgent appointments were available same day.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. 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. However systems for identifying risks to the service and the management of significant events and complaints needed to be strengthened

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

Good

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 flu, pneumococcus and shingles. Home visits for vaccinations were arranged for older patients who were housebound.

People with long term conditions

Good

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.

Families, children and young people

Good

Appointments were available outside of school hours and the premises were suitable for children and babies. Six week post natal reviews were routinely offered to women. 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.

Working age people (including those recently retired and students)

Good

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 1 pm each 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 cervical screening, NHS checks and well person clinics.

Summary of findings

People whose circumstances may make them vulnerable

Requires improvement 

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, 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. However the practice was not pro-active in encouraging people with learning disabilities to have annual health checks and take up was low compared to other practices locally.

People experiencing poor mental health (including people with dementia)

Good 

The practice maintained a register of patients with dementia and participated in the dementia identification scheme enhanced service. Practice nurses were able to administer injections as prescribed by psychiatrists, and a specific member of staff oversaw the weekly prescriptions to those at risk. Patients experiencing poor mental health 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 (a charity that supports people with substance misuse issues) and Drinksense.

Summary of findings

What people who use the service say

We spoke with 6 patients on the day of our inspection and also received 22 completed comment cards. Overall patients felt supported and described the practice's staff as helpful, efficient and empathetic to their health concerns. Some patients singled out specific clinicians for their excellent service and we received particularly good feedback from six patients about the kindness and responsiveness of the practice's nursing staff.

Patients told us they did not usually have to wait a long time once they had arrived for their appointment, and did not feel rushed during their consultation. Patients also reported a good experience with getting repeat prescriptions. One patient, with a number of long standing health problems, told us they had been pleased with the range of treatments offered by the GPs. They reported that they were invited for regular health checks and had confidence in the knowledge and skills of the staff.

People told us that the practice were responsive to their specific needs. For example, one patient told us they needed their test results urgently for insurance purposes and commented that staff had gone out their way get them the same day. Another patient told us that the nurse had agreed for them to come into the practice at a specific time each day to have their dressings changed, rather than have to wait in all afternoon for the district nurse to attend.

However, three patients told us that getting through on the phone in the morning could be difficult. Two patients felt the building was old and needed refurbishing; another that the waiting area was dark and drab. Patients reported that the reception area was not private enough and that staff could be easily overheard.

Areas for improvement

Action the service MUST take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Risk assess the need for staff members to be subject to a criminal records check. This includes staff who undertake chaperoning duties.
- Proactively support people with learning difficulties to attend annual physical health checks

Action the service SHOULD take to improve

- Improve the way patients' complaints are managed and ensure there is information easily available about how to complain.
- Improve the security and management of blank prescription forms.
- Improve the take up of cervical screening
- Ensure robust governance arrangements are in place to assess and monitor the quality of services provided.

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 advisor and a practice manager specialist advisor.

Background to Orton Bushfield Medical Centre

Orton Bushfield Medical Centre, in the NHS Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area and is contracted to provide general medical services to approximately 5402 registered patients. The practice area 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.

There are two full-time 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 has recently been approved as a training centre for Cambridge University students, the first of which will join in October 2015.

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. It serves a deprived area of Peterborough

The practice is open between 8.30am- 1 pm, 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.

Outside of practice opening hours, a service is provided by calling NHS 111. The out of hours' service for minor illness & injury is available to all patients who need emergency treatment when the surgery is closed.

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. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

Detailed findings

How we carried out this inspection

We carried out an announced visit on 9 June 2015. During our visit we spoke with a range of staff including three GPs, two nurses, 4 administrative staff, the practice manager and her deputy. We also spoke with 6 patients who used the practice.

We received 22 comments cards from patients, from a box left in the practice approximately two weeks before the inspection.

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

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 the significant events log which showed that 18 incidents had been recorded since 2011. We viewed minutes of a recent practice meeting involving all staff, where they had been reminded of the procedure of how to report significant events.

National patient safety and medicines alerts were actioned by the practice manager or her deputy who then disseminated them to all relevant staff. 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 drug prescribed to treat anxiety or partial epilepsy. All patients on this drug were reviewed and their treatment changed if appropriate. However a record of the alerts received or disseminated was not kept and there was no formal system in place to follow up that staff had received them.

Learning and improvement from safety incidents

We reviewed paperwork in relation to five significant events which demonstrated that the practice had learned from these and that the findings were shared with relevant staff. For example, in response to a problem with a two week wait referral, the practice's administrative protocols had been updated. New procedures meant that staff called the specialist department two days following the referral to ensure that the patient had been offered an appointment. Staff now checked to see if a referral had been received by the relevant department after 48 hours. If not, they rang to chase the appointment daily. Following concerns raised, a full audit of all contraceptive injections given over a nine month period had been undertaken to check they had been administered correctly.

Staff, including receptionists and nurses, were aware of recent significant events and told us they were discussed at the quarterly whole practice meetings. We viewed minutes of a meeting held in June 2015 and saw that recent significant events including vandalism of the building and a nurse referral that had been completed for the wrong patient had been fully discussed with staff. However, there was no formal system in place to identify common themes and patterns from significant events.

Reliable safety systems and processes including safeguarding

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. We saw that one of these GPs had undertaken recent safeguarding leads' training provided by the local CCG to ensure she had the knowledge and skills for this role. 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.

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. Monthly multidisciplinary safeguarding meetings were held to discuss children and adult safeguarding matters and we viewed minutes of meetings where vulnerable patients had been discussed.

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). Nursing staff mostly undertook chaperone duties; however reception staff occasionally acted as a chaperone if nursing staff were not available. However not all these staff 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 manager assured us that staff without DBS checks would no longer chaperone.

Medicines management

We checked medicines in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates.

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. Prescription forms were kept in a cupboard in the reception area, however the security and record-keeping practices for them were not in line with national guidance and we could not be assured that if prescriptions were lost or stolen this could be promptly identified and investigated.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. We checked two patient records which confirmed that the procedure was being followed. A specific named receptionist oversaw the weekly prescriptions of patients who were at risk because of their mental health or addiction, allowing them to get to know the patients and monitor their medication closely.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We viewed a sample of these which had been signed and dated, and were reviewed every two years. We saw evidence that nurses had received appropriate training to administer vaccines and immunisations.

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. We observed the premises to be clean and tidy. This included the consultation rooms, the reception and waiting area and the toilet facilities. Cleaning was undertaken by a private contractor and we viewed audits that had been completed regularly to ensure the premises were cleaned to a good standard.

One of the practice's nurses was the lead for infection control and showed a good knowledge of infection control procedures. She undertook regular audits of the premises, the next of which was due in November 2015. She told us she had facilitated hand washing training with staff.

There were adequate supplies of paper towels and liquid soaps for the use of patients and staff. Notices about hand hygiene techniques were displayed in staff and patient toilets. Curtains in consultation rooms were disposable and were changed regularly. Spill kits were available in each treatment room to manage any spillage of bodily fluids.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings) and a private contractor visited the practice weekly to conduct formal water testing.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. A schedule of testing was in place and the next annual calibration check for equipment was booked for 30 July 2015. Portable appliance testing had been completed in July 2014 and had been arranged again for 20 July 2015. We checked the equipment in one of the doctor's bag, and found it to be appropriate and in good working order.

Staffing and recruitment

There had been a number of changes in the practice team in the six months prior to our visit. One partner had stepped down and was now employed as a half time equivalent salaried GP. The practice manager had retired on grounds of ill-health and one of the senior nurses had also retired. However a new GP, nurse and practice manager had recently joined and additional administrative staff had been employed to deal with the practice's increasing work load. Staff told us that things felt more stable after a period of considerable staff turnover.

Requires improvement

Are services safe?

The practice did not have any policies and procedures in place for guidance about the recruitment of new staff. We looked at the personnel files for five members of staff employed and noted a number of shortfalls in their pre-employment checks. For example, two of the staff did not have any references recorded. The practice had employed a retired nurse to undertake patient note summarising, however no pre-employment checks had been obtained, despite her having access to confidential information about patients. We were told that all new staff to the practice underwent an induction to their role. However of the five personnel files we checked, there was only evidence that two of these staff had received an induction.

Professional registration checks had been undertaken for the practice's two nurses.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of medicines management and dealing with emergencies and equipment. An external contractor visited regularly to conduct a range of health and safety checks including water, fire alarm testing and emergency lighting. However, the practice manager reported that there was no specific risk log available for the practice and that formal assessments of risks associated with the service had not been completed.

The practice closely monitored repeat prescribing for patients receiving medication for mental ill-health or addiction and 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. In response to reception staff's concerns about dealing with patients expressing suicidal thoughts, one of the GPs had written a specific protocol to help them better manage this situation.

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 in November 2014. 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; however staff had not undertaken regular fire drills to practice how they would respond in the event of a fire.

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.

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.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance was easily accessible in clinical and consulting rooms. We were shown specific examples of where the practice's protocols had been amended and updated to reflect the most recent NICE guidelines. One of the nurse's told us that the practice manager sent round the latest NICE guidance and that she also attended the practice nurse forum every three months where guidance was discussed. She reported that this helped keep her knowledge and skills up to date.

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 told us they 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-terms 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 McMillan 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 they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. The practice was aware of the areas where performance was not in line with national or CCG figures and we saw that action had been taken to improve them. For example, in response to the low take up of flu immunisations, the practice had added extra vaccination sessions at lunchtimes and Saturdays. To improve the care of patients with diabetes, staff had specifically targeted patients with Type 1diabetes to encourage them into the practice for health reviews. The practice's total achievement score for 2013-2014 was just 70%. This had increased to 89 % for the year 2014-2015.

The practice showed us two clinical audits that had been undertaken in the last year. Both these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. One audit was undertaken to review the care received by patients with chronic obstructive pulmonary (COPD) disease on triple therapy. The first round undertaken in July 2014 demonstrated that improvement was needed in giving patients smoking cessation advice; in checking their inhaler technique and in the recording of their lung function test. As a result of this audit, a number of changes had been implemented at the practice including the use of a specific COPD template for recording patient reviews and the purchase of equipment to measure lung function. A second audit undertaken in January 2015 showed significant increase in the percentage of patients who had been offered smoking cessation advice, and those whose inhaler technique had been checked.

Following a request by the CCG's medicines management team, the practice had undertaken an audit of its antibiotic prescribing. Its aim was to assess if the prescribing of antibiotics likely to be associated with Clostridium Difficile infection (type of bacterial infection that can affect the digestive system), had complied with local antimicrobial

treatment guidelines. The practice found that antibiotics had been prescribed following guidelines in the majority of cases. However, the guidelines were still reviewed at a practice clinical meeting and a copy of them was displayed in all consulting rooms. In the second run of the audit, there was reduced prescribing of these antibiotics to patients.

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. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question.

The practice's prescribing rates were similar to national figures. For example, the number of antibacterial prescription items issues was 0.29%, compared to a national average of 0.28%. The number non-steroidal anti-inflammatory drugs items prescribed was 76%, compared to a national average of 71%.

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. This benchmarking data we viewed showed the practice compared well to other services 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. All patient referrals were reviewed by clinicians quarterly to monitor their outcome.

Effective staffing

We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support and safeguarding. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice's nurses told us they had received good training for their role, and training files we viewed also evidenced this. One nurse told us she had undertaken recent training in hypertension, coronary heart disease and diabetes, and attended regular study days to keep her skills and knowledge up to date. The nurses had undertaken annual appraisals that identified their specific learning needs. Non-clinical staff told us they received regular appraisals of their performance which they found useful and had helped them identify their training needs. Staff appraisals for this year were overdue, however the practice manager was aware of this and told us she had plans in place to organise 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. The practice was planning to introduce a specific prescribing clerk role to improve the way it processed and managed prescription requests from patients. The deputy practice manager was available to offer additional support at busy times and could cover staff shortages when needed. The ratio of GP sessions available to the number of registered patients compared well with national figures. Although the practice's diabetes nurse had left in April 2015, temporary cover was being provided by the local CCG. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and

Requires improvement

Are services effective?

(for example, treatment is effective)

pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice participated in a number of local admission avoidance schemes and emergency hospital admission rates for the practice were similar at 14.16% compared to the national average of 13.6% 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).

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. 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.

Information sharing

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. All staff had received training on how to use the system and one staff member told us she attended a regular users group to keep her skills up to date. The practice had implemented Summary Care Record for patients. Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

Consent to care and treatment

GPs we spoke with understood issues around patient consent. We saw that patients' wishes concerning whether or not they wished to be resuscitated had been recorded on their end of life plans so that their wishes could be respected. One of the GPs, who was planning to offer minor surgical procedures at the practice, showed us a form he had developed for patients to sign to indicate they understood the reason for their treatment, and actively consented to it.

Clinical staff were also aware of the Mental Capacity Act 2005, and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. To further their knowledge a specific training day about the Act had been organised for the whole practice team in August 2015.

Staff also demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). We saw that the procedure for dealing with children under 16, who attended for an appointment without an adult, had been discussed at a recent meeting involving all the practice's staff. Staff had been reminded to refer the young person to one of the nurse's so their competence and understanding could be assessed using Gillick guidelines. One nurse described how she had dealt with a young person whose parent was seeking contraceptive advice on their behalf. The nurse spoke knowledgeably about the complex consent issues involved in this particular case.

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.

Health promotion and prevention

All new patients registering with the practice were offered a health check. This included checks of their height, weight and blood pressure. The GP was informed of any health concerns detected and these were followed up if necessary. The practice also provided NHS Health Checks to its patients aged 40 to 74 years. Practice data showed that 154 patients in this age group had taken up the offer of the health check in the last year. Health checks for people with learning disabilities were also offered, however take up rates were low and figures showed that only 5% of those eligible to receive a health check had received one in the year 2014-2015. This was considerably lower than the previous year's total of 40%. One of the GPs told us that

Requires improvement

Are services effective?

(for example, treatment is effective)

health action plans for people with learning disabilities were completed; however this was done in a piecemeal fashion, when patients attended for other medical reasons. None of the health action plans we viewed were complete and therefore it was not clear how clinicians had an overall picture of the person's needs. The practice's performance for the cervical screening programme was 71%, which was below the national average of 82%.

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. Clinicians told us they regularly downloaded and printed off information for patients from a trusted information web site. One GP showed us a useful hand out of resources for older people and those with memory problems that she regularly gave out to appropriate patients.

Patients were encouraged to access the Smoking Cessation Service on site provided by the Healthy Living Team.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey which was published on 8 January 2015, and a survey of 140 patients undertaken by the practice's patient participation group (PPG). A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

We looked at data from the National GP Patient Survey based on 122 responses received. The practice was below average for its satisfaction scores on consultations with GPs. For example:

- 75% said the last GP they saw or spoke to was good at treating them with care and concern, compared to the CCG average of 83% and national average of 83%.
- 78% said the GP gave them enough time compared to the CCG average of 86 % and national average of 85%.
- 82% said the last GP they saw or spoke to was good at listening to them compared to the CCG average of 88% and national average of 87%.

However scores for the practice's nurses were well above average for satisfaction rates. For example:

- 90% said the last nurse they saw or spoke to was good at treating them with care and concern, compared to the CCG average of 81% and national average of 78%.
- 96% said the nurse gave them enough time compared to the CCG average of 83 % and national average of 80%.
- 92% said the last nurse they saw or spoke to was good at listening to them compared to the CCG average of 82% and national average of 79%.

These results also broadly aligned with the patients' participation group findings, where 73% of patients felt that the doctors listened to them, and 90% of patients felt the nurses did.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered a good service and staff were efficient, professional and caring. They said staff treated them in a way that they liked and were empathetic to their needs. We received particularly positive comments about the practice's nurses.

We were given examples where staff had gone the extra mile for patients such as delivering prescriptions to them and making welfare telephone calls to check they were ok. One patient told us that the doctors and nurses could not have been more caring when they had been diagnosed with cancer. This patient told us that the staff had gone out their way to help them.

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.

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.

Care planning and involvement in decisions about care and treatment

Information from the National Patient Survey published on 8 January 2015 showed that the practice scored a little below average in a number of areas. For example:

- 70% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75 % and national average of 74%.
- 80% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82 % and national average of 82%.

The practice's nurses scored significantly higher than average in these areas.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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. Results from the PPG's own survey

Good

Are services caring?

showed that 90% of those surveyed felt that their GP explained tests and treatments to them sufficiently. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/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 IAPT (improved access to alternative psychological therapies) 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 whom they could contact for additional support.

The practice's computer system alerted GPs if a patient was also a carer. 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 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (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 been introduced to the main reception desk to give patients at the reception desk more privacy.

Tackling inequity and promoting equality

The practice had access to a telephone interpretation service for people whose first language was not English. Longer appointment times were available for patients with communication difficulties. The practice web-site 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 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.

There were both male and female GPs in the practice; allowing patients to see a doctor of their preferred gender.

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 8.30 am to 6 pm Monday to Friday and appointments were available from 8.30 am to 12 pm, and 3.30pm to 6 pm. 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 2.30 pm. The practice had introduced a telephone triage system to better manage urgent requests for same day appointments. Patients we spoke with told us they could usually get an urgent appointment on the same day of contacting the practice.

Telephone consultations were available between 12 and 1 pm. Extended surgeries were offered on Monday evenings until 7.15 pm for patients who found it difficult to attend during normal opening hours. The practice's chronic disease nurses undertook home visits for patients' medical reviews if needed.

The patient survey information we reviewed showed patients generally rated the practice poor in relation to its telephone access. Only 47.5% of patients found it easy to get through on the phone, compared to the CCG average of 74%, and a national average of 72%. Telephone access was an area that the PPG had also identified as a cause for concern. The practice's telephone system had only two access lines, one of which was split between all the other services using the building. This resulted in considerable difficulty for patients trying to call the practice. However, the practice was well aware of these problems and quotes had been obtained to update the telephone system to improve access for patients.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and deputy manager dealt with most of them. Staff we spoke with on reception confirmed that they would escalate any patient complaint or concerns to the deputy practice manager. Minutes from the staff meeting held in June 2015 showed that the management of complaints had been discussed with staff to ensure they were aware of the correct procedure to follow.

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. However, there was no information about complaints in the waiting area, where patients would most likely be able to see it. The practice manager told us she would put some information up.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information provided to us by the practice showed that it had received four complaints between November 2014 and April 2015. Of these four, two had not been responded to within the practice's own timescales, and the responses did not include contact details of other agencies to 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). The response to one lengthy complaint was brief and had not addressed all the issues raised by the complainant. We found that the review and analysis of the complaints information submitted to us lacked detail, and did not demonstrate what action the practice had implemented in their light.

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. Although not all staff we spoke with were aware of these principles, they were clearly committed to providing a good quality service to patients. Staff were well aware of the challenges the practice faced, including the limitations of the building, the loss of long serving senior staff, 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.

Governance arrangements

There were clearly identified roles within the practice for both clinical and administrative areas. For example, there were clinical leads for prescribing, safeguarding and diabetes, and administrative leads for patient complaints, finance and human resources. We spoke with a number of clinical and non-clinical members of staff who were clear about their own roles and responsibilities.

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 had a number of policies and protocols in place to govern activity and these were available to staff in the reception area and on the practice's computers. However, there were no polices in place in relation to many of its personnel functions, including the recruitment of staff. Staff did not routinely sign off policies to indicate that they had read, understood them had agreed to abide by them.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance and QOF data had been discussed at meetings and used improve outcomes for patients. However, there was no systematic programme of clinical or internal audit in place and no arrangements for identifying, recording and managing risk. Although we found evidence that significant events and complaints were discussed at staff meetings, there was no formal procedure for analysing them regularly to identify common trends and areas for improvement.

Leadership, openness and transparency

Staff we spoke with clearly enjoyed their job and were enthusiastic about their work. They described an inclusive, open and supportive environment in which their suggestions and views were valued by senior staff. The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to their concerns.

Seeking and acting on feedback from patients, 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 regularly 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. The results of the survey were available on the practice's website. The practice's staff had provided presentations to the PPG explaining how the practice and NHS worked, and what specific staff roles were within the practice. We spoke with two members of the PPG who were very positive about the role they played and felt engaged with the practice. The chair of the PPG told us she had a good working relationship with the new practice manager and the partners, and felt her concerns were listened to and respected.

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.

Are services well-led?

Good

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

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.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and at attendance at local network meetings and study days. Although not all staff had individualised training plans, they told us that their training needs were discussed at length with them in their annual appraisals.

Staff were aware of the practice's whistle blowing policy and told us they felt able to raise concerns about a colleague's practice if necessary. We found evidence that staff had done this appropriately, allowing for swift action to be taken and patient care to be reviewed.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed Regulation 19 - Fit and Proper Persons Employed Recruitment procedures must be established and operated effectively to ensure the safe recruitment of staff. Regulation 19 (2)(3) Health & Social Care Act 2008 (Regulated Activities) Regulations 2014

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care Regulation 9-Person Centred Care The number of people with a learning disability who receive an annual health check must be increased. Regulation 9 (3) Health & Social Care Act 2008 (Regulated Activities) Regulations 2014