Jenner Health 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.

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Summary of findings

Overall summary

Jenner Health Centre provides a range of primary medical services to approximately 7,900 people from their premises in Turners Lane, Whittlesey.

During our visit we spoke with 13 patients and two representatives of the practice's patient participation group (PPG). A PPG is a group of patients that work together with GPs to improve services and to promote health and improve the quality of care. We spoke with ten members of staff including two GPs and two nurses. We looked at procedures and systems and considered whether the practice was safe, effective, caring, responsive to patients' needs and well led.

All of the patients we spoke with were very complimentary about the service. They told us that they were treated with respect and they were satisfied with the care and treatment they received. We saw that the results of patient surveys carried out by the practice showed that patients were pleased with the service and that the practice had responded to their views and complaints.

We met and listened to the views expressed by several support organisations for vulnerable people at a public listening event. We consulted with the Clinical Commissioning Group (CCG) the NHS England Local Area Team and with Local Healthwatch.

We examined patient care across six population groups: older people, people with long term medical conditions, mothers, babies, children and young people, working age people and those recently retired, people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health. We found that care was tailored appropriately to the individual circumstances and needs of patients in these groups

We found that Jenner Health Centre had procedures in place for reporting, recording and analysing significant events and incidents. There were procedures for the safeguarding of vulnerable adults and children.

The practice had procedures in place to deliver care and treatment to patients in line with the appropriate standards. We also saw evidence of effective working with multidisciplinary teams.

The practice was responsive to patients' needs. Patients were given the opportunity to give their views and the practice demonstrated they listened to and responded to their patient participation group.

We found that improvements **must** be made to the safe prescribing and storage of medicines.

Improvements **must** be made to the practice's infection control procedures.

Improvements **should** be made to the practice's policy for safeguarding vulnerable adults.

The practice **should** ensure that patient's privacy is maintained whenever patients use an examination couch.

Improvements **should** be made to the analyses and shared learning around significant events to ensure nurses are included in this process when it is appropriate.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Jenner Health Centre did not provide a safe service. The provider was in breach of the regulations because there were not suitable infection control and prevention measures in place. They were also in breach of the regulations for the dispensing of medication because medicines had not been consistently dispensed according to established guidelines.

Are services effective?

The practice was effective. There were procedures in place that ensured care and treatment was delivered in line with appropriate standards. Staff were trained to work effectively and worked well with other providers in the area. The use of clinical audits to improve services was minimal and supervision of clinical staff was not evident.

Are services caring?

All the practice staff demonstrated they were caring and considerate of patients' feelings. Clinical staff provided suitable information to patients about their condition and took time to explain and check that patients understood what was being said to them. Patients spoke very positive about the care and attention they received. GPs provided appropriate support during end of life care.

Are services responsive to people's needs?

The practice was responsive to patient's needs. Patients and other key local service providers commented on the efficiency and how reliable and responsive the practice were.

Patients told us they were able to get an appointment at the practice and were able to see a GP on the same day for urgent appointments.

Are services well-led?

The practice has scope to improve their systems for monitoring the quality of their service. Monitoring risks and audits had not been consistently applied over time to identify and assess the risks to the health, welfare and safety of patients. The practice also has scope to improve the learning from events and incidents in a formalised, practice wide manner.

The practice demonstrated positive leadership through their considerate and responsive approach to providing care to patients. An approach to attentive care was embedded within the culture and the attitudes of staff.

Summary of findings

The practice had encouraged and facilitated and worked closely with their established Patient Participation Group.	

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

Reviews of medication for patients with dementia and end of life care plans in place were this was necessary. There were named GPs for patients who received end of life care.

Care was tailored to individual needs and circumstances. There were regular 'patient care reviews' involving patients and their carers. The practice had worked very closely with six residential care homes to ensure that patients' needs were prioritised and each care home had its own named GP. Patients had been regularly involved in decision making, such as making decisions relating to resuscitation. This showed that patients' views had been listened to and that their choices and instructions regarding resuscitation had been recorded.

People with long-term conditions

Patients with long term conditions were provided with a suitable range of support services and information which demonstrated that Jenner Health Centre provided a responsive service to these patients. Patients with coronary heart disease and patients with Venous Thromboembolism (VTE), Deep Vein Thrombosis (DVT) and diabetic patients who had been identified for referral for specialist treatment, had been regularly reviewed by the practice.

Regular multi-disciplinary meetings were held to ensure that people affected by dementia received the care they required. There were several care homes that the practice had arrangements with to provide care and treatment.

The Quality Outcomes Framework (a national incentive to reward the measurement of treatment for identified patient types) was kept up to date and had been used to ensure that patients with different long term conditions were treated appropriately. Appropriate patient information had been shared and made known to out-of-hours services. All this ensured that patients with long term conditions were monitored and the practice provided care and treatment that was necessary.

Mothers, babies, children and young people

The Patient Participation Group (PPG), which is an established group of patients who help to develop a partnership with the practice, had agreed an initiative to seek and include younger patients' views, because they felt they were underrepresented in this group.

Summary of findings

The practice offered specific lifestyle advice to pregnant patients. Regular nurse led baby clinics were offered to ensure postnatal six week checks were carried out for mothers and babies.

The practice worked closely with local health visitors to offer a full health surveillance programme for children under five. Checks were also made by the practice to ensure the maximum uptake of childhood immunisations.

There was health promotion information in the waiting area specifically aimed at mothers and young people for cervical screening and sexual health.

Young patients were provided with information about counselling services which were available.

The working-age population and those recently retired

Jenner Health Centre monitored the availability of appointments requested and the availability of GPs and nurses on a daily basis. As a result, the practice decided to provide a late evening surgery until 8 pm on Mondays so that patients who worked had access to primary care. As well as the out of hours GP service, patients are directed to Peterborough City Care Centre (PCCC) should they require treatment outside of the surgery hours.

The smoking status of patients was routinely recorded and advice about local smoking cessation services were discussed with patients during consultations. General health promotional material was easily accessible on the practice's website.

People in vulnerable circumstances who may have poor access to primary care

There were no barriers to accessing the services at the practice for any vulnerable group. The staff believed that patients could access the practice's services without prejudice. The practice was aware of and was providing services for people in vulnerable circumstances, although the practice area did not have a significant homeless population. We were informed that homeless people would be seen by a GP, should they present at the surgery.

The practice had provided leaflets in their premises and similar information on their website about the out-of-hours arrangements and the walk-in clinics and minor injuries clinics that served the area.

The practice had a register of patients with a learning disability. We saw that the annual health checks that should be offered to patients with a learning disability had commenced in July 2014.

Summary of findings

People experiencing poor mental health

Patients experiencing poor mental health were assured the practice would review their health annually. Records showed that patients' medication and their physical health had been reviewed when necessary in line with NICE (National Institute for Health and Care Excellence) guidelines.

There was information available on the website and at the surgery for patients with poor mental health directing them to a number of support services, such as the Samaritans, healthy living and Drinksense (a local support and advice service).

Summary of findings

What people who use the service say

The feedback we received from each of the 16 patients we spoke with during the inspection was very positive. They told us they had experienced kind and attentive treatment from the staff whenever they had called the practice or visited in person. Patients told us that they appreciated the friendly and caring attitude shown by all staff. Some patients expressed concerns at having to wait longer than they wanted when they had made routine appointments. Patients said that whenever they required an urgent appointment, the surgery had responded and made them an immediate appointment, or a GP had visited them at home on the same day.

Eleven Patients completed CQC comment cards to provide us with feedback on the practice. Their comments showed that patients had experienced a satisfactory service from attentive and caring staff. Details on some of these comment cards demonstrated that GPs had responded immediately to patients' needs in a kind and considerate manner and that timely referrals to hospitals had been made.

The findings of the annual patient surveys carried out by the practice that had been published on their website had been discussed with the patient participation group (PPG). Improvement actions, such as the changes made to the telephone appointments system, had been agreed between the practice and the PPG and put into place.

Areas for improvement

Action the service MUST take to improve

Infection prevention measures must be implemented to ensure that the role of the infection prevention nominated lead is made clear. Appropriate infection prevention arrangements must be in place in place to monitor the standard of cleanliness throughout the building and to identify and reduce the cross infection risks associated with the use of all of the treatment rooms, including the three rooms used for minor surgery. These rooms must be risk assessed for infection prevention standards, if they continue to be used for clinical treatment.

Medicines must be safely stored at all times. Prescriptions for all medication prescribed by the practice must include the signature of the authorising GP or nurse prescriber. Controlled drugs that are out of date must be appropriately destroyed.

Action the service SHOULD take to improve

Improvements should be made to the practice's policy for safeguarding vulnerable adults.

The practice should ensure that patient's privacy is maintained whenever patients use an examination couch.

Improvements should be made to the analyses and shared learning around significant events to ensure nurses are included in this process when it is appropriate.

Outstanding practice

Our inspection team highlighted the following areas of good practice:

The practice has a sound reputation and a record of timely response to patients living in residential care homes. They have consistently ensured that relatives are included and are part of the planning of care and treatment. Six residential care services we spoke with expressed positive comments about the caring attitude shown by all the practice staff and of the immediate and prompt responsiveness from GPs. Each care home praised the standing arrangements the practice had for the frequency and the regularity of visits to patients in the homes when the visiting GP had provided a mini surgery at each of these residential care homes.

On several occasions different GPs had anticipated that a patient's condition might deteriorate and their need for

care and treatment when the practice was closed. On many occasions the GPs had arranged for the home to contact them should there be a decline in a person's condition and had agreed that they would personally respond and see the patient. This extra care was over-and- above the usual practice hours and had ensured that patients had not needed to be admitted to hospital unnecessarily and when this could be avoided. This arrangement had been made after consulting and in agreement with the patient and when they had made a choice and decision to remain at home. The benefit of this continuity of care and personal treatment was greatly valued by patients and by the care home services we spoke with.

Jenner Health 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, a second CQC inspector, a CQC pharmacist inspector and a specialist advisor with experience in practice management.

Background to Jenner Health Centre

Jenner Health Centre is within the Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) area and provides a range of primary medical services to approximately 7,900 patients. A clinical commissioning group is an NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. The practice is located in the centre of the small market town of Whittlesey and was purpose built as a GP surgery during the late 1960s.

The practice consists of four partner GPs, a full time salaried GP and the regular use of a locum GP. There are two practice nurses and two healthcare assistants and a practice manager employed. The reception and administration team consists of six staff. The practice also employs a dispensary manager and two dispensary staff.

The out-of-hours service is provided by Cambridgeshire Community Services.

Why we carried out this inspection

We inspected Jenner Health Centre as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

We conduct our inspections of primary medical services, such as Jenner Health Centre, by examining a range of information and by inspecting the practice to talk with patients and staff. Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew about the practice. We held listening events for support networks for vulnerable people and a public listening event and reviewed the comment cards that patients had completed at the practice.

We carried out an announced visit on 26 August 2014. During our visit we spoke with 16 patients and with carers and parents whilst they were waiting to attend appointments. We spoke with two representatives of the Patient Participation Group. We also spoke with a range of staff, including two nurses, two GPs, several reception and administration staff and the practice manager. We observed some interactions between staff and patients and looked at the practice's policies and other general documents.

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

Detailed findings

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care

People experiencing poor mental health

Are services safe?

Our findings

Safe Track Record

We found that Jenner Health Centre had effective arrangements in place and a culture that encouraged staff to report safety incidents in line with national and statutory guidance. Safety incidents, near misses and complaints had been reported. There were clear accountabilities for incident reporting. Staff were aware of their role in the reporting process and told us they have been encouraged to report incidents.

Significant events identified by the practice staff had been recorded and analysed. Three recent significant events had been reviewed by the practice. Complaints and incidents had also been investigated in a timely and suitable manner in which the complainants had been kept informed. As a result, changes had been made such as the new procedures relating to the administration of medication.

Medicine management errors had been recorded, the records that were available for us to see were from January 2014 to May 2014 only.

Learning and improvement from safety incidents

There was evidence to show that clinical meeting and team meetings were held on a regular basis where incidents and events had been discussed. Significant events analyses (SEA) of reported events that had taken place had been included. We saw that actions had been taken and new processes developed as a result of these events that related to clinical staff recording allergies, communicating blood test results and the administering of incorrect medicine.

Dispensing practices had been amended as a result of incidents and errors arising. We were informed that an amended dispensing policy had been introduced in March 2014, although the lead dispenser confirmed that the learning and competency of staff had not been assessed since this date, although it was scheduled for September 2014.

There was a named clinician at the practice with responsibility to ensure that official safety alerts about medical devices and medicines were shared appropriately within the practice.

Reliable safety systems and processes including safeguarding

Staff informed us they would refer a safeguarding concern to the safeguarding lead. Staff also told us they would refer to the safeguarding policies if in doubt.

The safeguarding children policy included the training that staff would receive and directed staff to refer a safeguarding concern to their Local Authority Social Services team. The policy included a named practice lead responsible for safeguarding children arrangements within the practice.

The safeguarding vulnerable adult's policy did not state who the practice's responsible person for overseeing the policy was. The level of training that staff should receive had not been included in the policy. This did not guide staff about the level of knowledge and training that staff should receive, although they had received training in safeguarding.

The practice had a chaperone policy. Two patients we spoke with told us they had been offered a chaperone at previous consultations. Staff told us they had occasionally acted as a chaperone when a patient had requested this.

Monitoring Safety & Responding to Risk

Reception and clerical staff had instructions around how to manage a telephone call when a patient contacted them in an emergency. There was a duty system for GPs to ensure one of the nominated GP partners covered for their colleagues, for example for emergency home visits and checking blood test results. There was a system in place to inform nurses about any medical alert warnings or safety notifications.

A GP told us that they had begun to use a risk monitoring method known as 'risk stratification', a process designed to identify which patients were most at risk of re-hospitalisation. We were informed that this had identified several patients who were at risk and that risk management plans had been put into action for those patients.

We saw that the practice manager carried out searches of the records system to identify whether patients had attended the practice for treatment or medication reviews or for scheduled vaccinations. This ensured that patients, particularly those with long term conditions, were not at risk of missing those reviews.

Are services safe?

Medicines Management

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We looked at all areas where medicines were stored, and spent time in the dispensary observing practices, talking to staff and looking at records. The dispensary was tidy and operated calmly with adequate staffing levels. Patients we spoke with told us they were happy with the supply of their repeat prescriptions and reported no delays in obtaining their medicines. However, we saw that repeat prescriptions were handed to patients without a GP's, or a Nurse Prescriber's signature.

We asked about the arrangements in place for the security of medicines and noted that arrangement for the security of keys to the dispensary was not robust. We observed that the dispensary was sometimes left open and unattended.

The refrigerated medicines, including injectable medicines were kept securely in clinical areas of the surgery. Records of vaccines and medicines requiring refrigeration showed they had been stored within the correct temperature range. We saw that the surgery had a small supply of medicines for use in an emergency, which were safely stored, although there were no records available about expiry date checks. We therefore could not be assured that staff monitor and check emergency medicines to ensure they remain safe to use.

We checked a sample of controlled drugs and found we could account for them in line with registered records. Controlled drugs are medicines that the law requires are stored in a special cupboard and their use recorded in a special register. However, we found that controlled drug checks were not being conducted and recorded on a regular basis so we could not be assured that if there were controlled drug discrepancies they would be promptly identified and investigated. We also noted there were a number of controlled drugs, including morphine sulphate and diamorphine ampoules, that had expired early 2013 and had been put aside, but had not been disposed of.

Dispensing staff had recorded a small number of dispensing errors since the start of 2014. Staff gave examples of how dispensing practices were amended as a result of incidents arising. We found that staff had received training to undertake dispensing tasks but had not been assessed for competency. Therefore we were not assured that patients were dispensed their medicines by staff whose competency was known, or was assured.

Cleanliness & Infection Control

The practice appeared clean and tidy. Daily cleaning of the premises had been carried out by a contracted cleaning agency, but no cleaning checks had been carried out by the surgery for the daily cleanliness of the premises.

The infection prevention lead, identified in the practice's infection prevention policy, was not able to inform us what their responsibilities were. They told us that that the practice did not have a system in place for checking the daily cleaning or to regularly monitor or audit the cleanliness of the premises. This was also confirmed by another member of staff.

We found concerns relating to three small treatment rooms numbered 1, 2, and 3 that we were told were allocated to specific GPs. Two of these rooms had carpet floor covering that was a potential contamination risk and there were no risk assessments relating to the cleanliness of this flooring. Two treatment rooms had cracked Formica sink surrounds and peeling surfaces, worn sinks enamel and wooden splash backs that all presented hygiene risks. In one room we saw a tray of uncovered and apparently used instruments that included two steel speculums, a nail brush and visibly soiled steel scissors. From our conversation with a GP when we provided feedback, we understood that these instruments had probably been left like this for two weeks. We were also informed that one of the treatment rooms was unused, although this room had not been locked and there was no signage indicating this was not in use.

We saw that the paper towel holders in two of these treatment rooms were too large for their wall mounted holders and had been placed on the floor.

A further nurse treatment room was suitably fitted, appeared clean and had recently been fitted with new impervious hard flooring. Some of the GP consultation rooms had carpeted flooring and there was no available risk assessment for this flooring.

Staffing & Recruitment

Recruitment procedures were in place to ensure that staff had been safely recruited.

We looked at the recruitment files for four members of clinical staff and for two members of staff in non-clinical positions. There had been no Criminal Records Bureau or a Disclosure and Barring Service (DBS) check obtained for two clinical staff or for one non clinical member of staff,

Are services safe?

although the risks had been assessed in these cases. For a locum GP, employed to work at the practice on an occasional basis, there was a record of their professional indemnity. The locum GP was well- known to Jenner Health Centre partners. We discussed this with the practice manager who informed us that checks of this GP's suitability had been made, although they had not been recorded or retained. We were subsequently informed that these checks and the suitable information had been retained by the practice.

Dealing with Emergencies

The practice had a suitable business continuity plan that documented the response to any prolonged period of events that may disrupt the service or compromise patient safety. For example, this included loss of premises and essential equipment.

The practice had a risk assessment in place which related to fire hazards and health and safety. An automatic fire system was fitted and had been tested weekly and serviced annually. There was a certificate in place to demonstrate that the building met the Regulatory Reform (Fire Safety) Order 2005.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff explained that emergency procedures had been used successfully on a patient who had collapsed. All staff had been included in the basic life support training sessions.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had an effective system using checklists to monitor the dates of emergency medicines and equipment which ensured they were discarded and replaced as required.

We found that there were only two height adjustable examination couches available to patients. Other couches that were used in treatment rooms were old and non-adjustable and patients were expected to use these with a wooden foot stool, where this was necessary. There were not any risk assessments for use of this equipment. We were told that patients were offered an adjustable couch in another treatment room, should they need to use this.

We saw that portable appliance testing had been regularly carried out on electrical equipment throughout the surgery.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Care and treatment was delivered in line with recognised best practice standards and guidelines.

Clinicians we spoke with were aware that it was their responsibility to adopt National Institute for Health and Care Excellence (NICE) guidelines after any revised guidelines had been shared amongst all clinicians. Patients received up to date tests and treatments according to their needs.

The clinicians we spoke with described the processes to ensure that written informed consent was obtained from patients whenever necessary. We were told that verbal consent was recorded in patient notes where appropriate. We also observed that chaperones were made available when requested. Clinicians were aware of the requirements of the Mental Capacity Act (2005) used for adults who lacked capacity to make specific decisions. They also knew how to assess the competency of children and young people to make decisions about their own treatment.

Management, monitoring and improving outcomes for people

The practice has a history of effective treatment for patients that was cited by other health and social care providers that had avoided and reduced unplanned admissions to hospitals. We were informed by six residential care homes how effective this initiative had been and how care had also improved for patients as a result of this approach to providing care and treatment. Care plans had been put in place for elderly patients most at risk of unplanned admissions and regular review meetings were held to assess their effectiveness.

Only one clinical audit had taken place since 2012 which was a small scale audit relating to acute admissions and did not relate to the practice. An audit had been identified by the CCG for the practice to undertake relating to antipsychotic prescribing but had not yet commenced, although it was not due to be completed until January 2015. There was therefore scope to better ensure that improvement and learning of risks through the use of auditing could be achieved.

Doctors in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. A nurse who provided minor surgery told us they had been appropriately trained and had kept their professional learning and nurse registration status up to date.

Effective Staffing, equipment and facilities

There were not suitable arrangements in place to ensure that all staff employed for the purposes of carrying on the regulated activities were appropriately supported in relation to their responsibilities. The GPs in the practice participated in the appraisal system leading to revalidation of their practice over a five-year cycle. Appraisals of nursing staff and other non-clinical staff had not been carried out within the previous year but that these were due to commence in September 2014 since a new practice manager had been employed.

We looked at the training arrangements for staff and found that staff had received a range of training that included infection prevention, health and safety information governance, safeguarding children and vulnerable adults and Cardio Pulmonary Resuscitation (CPR). We discussed with the practice manager that up to date records of the training staff have received should be retained. There was no formal record of the training undertaken by staff although we saw this had been initiated by the new practice manager and we assured they would be compiled as soon as possible.

Nurses informed us they managed their own professional development training. Non clinical staff told us they also had received training on customer awareness and fire prevention.

The professional registration of the two nurses with the Nursing & Midwifery Council (NMC) and the five GPs' with the General Medical Council (GMC) were current. The GPs were at different stages of their five year revalidation process.

Working with other services

Six residential care homes who we spoke with praised the efforts of the GPs and all the staff in the joint working arrangements. The GPs attended each residential care home at least once each week to hold a mini clinic for as many patients who required a GP. Each care home told us that the attention shown by the practice to ensure that patients received effective care was excellent. They also

Are services effective?

(for example, treatment is effective)

told us that the practice provided appropriate support to avoid unnecessary hospital admissions and enable patients to remain at home to receive planned end of life care.

There was effective information sharing with the out-of-hours provider and with district nurses. We saw that information regarding patients who were at the end of life was shared with the out-of-hours provider. This ensured that care and support would be seamless if the patient needed a GP out of hours.

One of the GPs led a regular monthly multidisciplinary team meeting to review patients at end of life, patients with complex needs and to minimise unplanned admissions. These meetings included district nurses, and community matrons.

We saw there was an effective and a clear process for recording information from other health care services such as blood test results, discharge summaries and out of hours providers.

Health Promotion & Prevention

The practice website directed patients to a variety of different organisations who provided advice and support for a range of health care needs such as drug and alcohol services, dementia care and support, carers' services and eating disorders.

All new patients were offered a consultation. There were regular clinics for patients with complex illnesses and diseases. A full range of screening tests were offered for diseases such as prostate cancer and ovarian cancer. Vaccination clinics were organised on a regular basis and monitored to ensure those that needed vaccinations were offered them. Patients were encouraged to adopt healthy lifestyles and were supported by services such as smoking cessation, alcohol management and exercise.

The nursing staff explained that when patients were seen, prompts appeared on the computer system to remind staff to carry out regular screening, recommend lifestyle changes, and promote health improvements which might reduce dependency on healthcare services.

There was a range of leaflets available in the practice and further information available on their website about family health, travel advice, long term conditions and minor illnesses. These web links were easy for patients to locate.

Family planning, contraception and sexual health screening was provided at the practice. Information about different types of counselling services was available for patients.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Patients, relatives and other service providers we spoke with told us that all staff were extremely caring and had made certain the patients were at the centre of their care. We heard examples of several occasions when GPs had acted with kindness and empathy and took time when speaking to patients. We were told that GPs provided a high level of individual care for patients and that they particularly ensured that conversations were a two-way affair whenever they spoke with patients. Patients said that they were given the time they needed by GPs and by nurses to ensure they understood the care and treatment that was discussed with them.

We observed patients being treated with respect and dignity by reception staff and by nurses and GPs when they greeted them. Staff demonstrated caring and considerate attitudes. One nurse described the support they gave to patients and ensured that patients had understood any advice they had been given.

A privacy and dignity policy was in place and all staff had access to this. Privacy screens and window blinds were fitted in treatment rooms, although not all treatment rooms had a privacy curtain around an examination couch. A nurse and a GP told us that the curtains were always used and that the door was closed when personal procedures were carried out.

One patient told us that following the death of a relative, the practice had contacted them to ensure they were safe and were coping. Bereaved relatives were offered the opportunity to speak with a GP, or a nurse. An external counselling service was available, should this be necessary.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they had sufficient time to discuss their concerns with their GP and said they never felt rushed. Feedback from the

comment cards showed that patients had been involved in the different treatment options that had been discussed with them.

We saw evidence of patient consent for procedures including immunisations, injections, ear syringing and minor surgery. Patients told us that nothing was undertaken without their agreement or consent at the practice. The number of patients with a first language other than English was very low. The practice staff knew they could access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

Where patients did not have the mental capacity to consent to a specific course of care or treatment, the practice had acted in accordance with the Mental Capacity Act 2005 to make decisions in the patient's best interest.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to people's needs

The practice understood the different needs of the local population and took appropriate steps to tailor its service to meet these needs. The practice had a significant proportion of patients on its list with dementia. We were shown measures the provider had taken to target patients with dementia for those living in their own homes and in residential care settings. GPs told us that when home visits were needed, they were usually made by the GP who was most familiar with the patient. This was confirmed by patients and by six residential care homes that we spoke with.

The practice was responsive to patient needs. For example, practice nurses and a GP had made a decision to visit certain vulnerable patients in their own homes. This included vaccinations for the elderly, annual health checks for patients with learning disabilities and for patients with poor mental health.

The practice was situated in a purpose built surgery. There was a level access to the front door and automatic double doors to assist patients with mobility problems or with children in push chairs. We observed a few patients who used a wheelchair and noted that access to corridors and consultation rooms was reasonably easy. .

Access to the service

Patients were able to access the service in a way that was convenient for them. There was appropriate information on the practice's website informing patients of the several ways to access their services, including making appointments, obtaining test results, ordering repeat prescriptions, cancelling appointments and speaking to staff. Patients could make appointments by phone or on line and in person.

Access to other services, such as out-of-hours and minor injury and illness units and a local weekend primary care centre ensured that patients were able to access appropriate healthcare services when the practice was closed.

The practice had recently employed additional staff, a nurse practitioner and a health care assistant, in response to the increased patient demand and to ensure an improved service was provided.

Meeting people's needs

Systems were in place to ensure any referrals, for secondary care and routine health screening appointments such as for cervical screening and DVT pathways, were made in a timely way. Patients were able to choose which hospital they wished to attend and told us that any referral to secondary care had been discussed with them and arranged in a timely way.

An effective process was in place for managing blood and test results from investigations. When GPs were on holiday the other GPs covered for each other. Patients said their test results had been either given immediately, phoned through by a GP, sent by letter or when they phoned the surgery.

Concerns & Complaints

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

There was a complaints process displayed in the waiting room, on the practice web site and in the practice leaflet. Patients we spoke with had not had any cause to complain but they believed any complaint they made would be taken seriously.

We saw the practice's log and annual review of complaints it received. The review recorded the outcome of each complaint and identified where learning from the event was necessary.

Are services well-led?

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

Our findings

Leadership & Culture

Staff spoke positively about their employment at the practice. They told us they were supported in their employment and described the practice as having a supportive culture and being a good place to work.

Nursing staff said they were supported to communicate informally and through meetings, although we were informed that nurses had not regularly attended the weekly clinical meetings but would do so in the immediate future. We were assured by staff and by team leaders that the practice had an open door policy and listened to staff and to patients' complaints.

We were told by nurses how the initiative to triage patients had been raised by staff and had been adopted by the practice. This had been supported by clear leadership control over the part of the triage process involving non-clinical staff who answered phones. We saw how this was adhered to and managed by a senior administrator and the practice manager.

Governance Arrangements

The practice had a named GP lead for clinical governance. The systems in operation to manage governance of the practice were formalised. We read the minutes of the nurse meetings and non-clinical team meetings, practice meetings and clinical governance meetings that the practice held. We saw that the clinical governance meetings were held either two or three monthly although nursing staff were not always present at these meetings, which meant they did not have opportunities to participate in the governance of these matters.

We saw that matters that had an impact on patient care and safety had been considered and disseminated to staff through the team leaders to staff if this was appropriate to their role.

Systems to monitor and improve quality & improvement (leadership)

Significant events analysis (SEA), clinical issues and complaints had been discussed at clinical meetings. Non clinical staff told us these had been discussed with them, if they were appropriate to their roles. However, nurses were not always present at the clinical governance meetings, which meant they had not always shared the learning from these events. There was no evidence of any subsequent monitoring to establish whether staff had learned, or that any changes following a SEA, or an incident were embedded in everyday practice.

We found there was scope to improve the practice's approach to monitoring medicine management and infection prevention and practice focussed clinical auditing to drive improvement. These point have referred to elsewhere in this report.

Monitoring had been carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward good practice. The practice was able to demonstrate that it was meeting the QOF targets.

Patient Experience & Involvement

The practice was active in obtaining feedback from patients. Regular annual surveys had been conducted and the results and actions were posted on the practice website. The findings from the surveys were positive.

CQC comment cards that patients had been asked to complete as a part of this inspection, showed patients had positive experiences of the service.

Two representative of the Patient Participation Group (PPG) that we met during our visit told us the practice was a listening service and was considering their request for the practice to open on a Saturday morning. The group enjoyed regular meetings with the regular meetings with the GP partners and the Practice Manager which they said had ensured the practice was made aware of patients' views. As a result, patients had been invited by the practice to attend a practice presentation about medication which they told us had helped them to become better informed about medication. We also found that the practice had responded to patients views expressed through the PPG in relation to the telephone appointments system and action had been taken to improve this part of the service.

Identification & Management of Risk

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice.

The practice did not have a clear arrangement, or a system for identifying, recording and managing risks. The practice had completed one clinical audit or non-clinical audit during the past two years.

Are services well-led?

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Our findings

We found that reviews of medication for patients with dementia were in place. There were named GPs for patients receiving end of life care and there was anticipatory treatment arrangements made when pain relief was required for patients living at home or in a residential care home. We found that for patients who were terminally ill, the GPs had provided strong support and empathy where patients had chosen to remain in their own home. We saw that patients' decisions and preferences regarding resuscitation had been sought and used to inform GPs.

Care for older patients was tailored to individual needs and circumstances. There were regular 'patient care reviews' involving patients and in a significant number of cases, relatives and carers had been included. Unplanned hospital admissions and readmissions for this group were largely prevented because of the practices philosophy and efficient support to treat patients in their own homes. We found that the GPs worked closely with six residential care homes. Each of the residential care homes told us that the responsiveness and efficiency of the GPs and staff at the practice was exemplary.

There was wide representation of older people who participated in the Patient Participation Group surveys to share their experience and views about the service.

The practice actively targeted older people to attend surgery for 'flu vaccinations and staff always offered additional relevant health information. Housebound patients were visited by the doctor or nurse for routine 'flu vaccinations. The practice also targeted patients over 75 to offer them a vaccination against shingles.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Our findings

Patient with long term conditions were provided with a suitable range of support service and information and a suitably responsive service by Jenner Health Centre. The practice regularly monitored patients with long term conditions by providing annual reviews. GPs, nurses, a specialist diabetic nurse and a Health Care Assistant (HCA) provided this service. One of the GP partners had recently developed a community **deep vein thrombosis (DVT)** diagnosis pathway that had been shared across the Local Commissioning Group (LCG). The practice conducted patient testing for anticoagulant monitoring and dosing. Monitoring of high risk drugs such as disease-modifying anti-rheumatic drugs (DMARDs), which are medicines prescribed for rheumatoid arthritis was carried out by the practice.

Information about support services for blind and partially sighted patients and their carers was available on the practice website. Practice staff informed us that they provide verbal advice and support to patients who are registered blind. Patients with coronary heart disease and patients with diabetes had been identified had been referred for specialist treatment and had been regularly reviewed by the practice.

Patients affected by dementia had a named GP. We saw that several social and health referrals had been made and that other no statutory support services were also involved in patients care planning. Regular multi-disciplinary meetings were held with the practice to ensure that people affected by dementia were receiving the care they required. This demonstrated the practice was aware of the holistic needs of patients and had ensured that patients received the support they required.

There were several care homes that the practice had arrangements with to provide care and treatment. We saw evidence that patients had received regular health checks and their medication was kept under review. These patients' electronic records included an alert so that practice staff were able to immediately recognise their needs.

The Quality Outcomes Framework (the annual reward and incentive programme detailing GP practice achievement results) had been kept up to date and used by the practice to ensure that patients with different long term conditions were treated. Patients had been provided with a range of information about out-of-hours services, walk in clinics and emergency care arrangements. Patient information had been shared and made known to out-of-hours services, where there was a history of such services being used. All of this ensured that patients with long term conditions were continuously monitored and the practice was providing regular care and treatment that was necessary and emergency treatment had been anticipated.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Our findings

The Patient Participation Group (PPG) and the practice had agreed to start an initiative to seek and include younger patients' views.

The practice offered lifestyle advice to pregnant patients. The practice held a nurse led baby clinic and offered every new mother a postnatal check six weeks after the birth of their baby.

The practice worked with local health visitors to offer a full health surveillance programme for children under five. Checks were also made to ensure the maximum uptake of childhood immunisations.

There was health promotion information in the waiting area specifically aimed at mothers and young people for cervical screening and sexual health.

Young patients were provided with information about counselling services that were available at the surgery. The practice worked in collaboration with another provider to ensure that young patients could access the counselling service without having to make a referral. This arrangement had ensured that young people were supported and could access a range of support services. One young person we spoke with described how effective the service had been for them and how they were able to quickly access this.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Our findings

Jenner Health Centre monitored the availability of appointments and the availability of GPs and nurses on a daily basis. As a result, the practice provided a late evening surgery until 8 pm on Mondays so that patients who work could get access to primary care. Jenner Health Centre is a rural practice and provides a minor injury service to all their patients, some of which are walk-in arrangements and are accessible by patients who are working locally. As well as the out-of- hours GP service, patients are directed to Peterborough City Care Centre (PCCC) during out-of-hours.

One patient we spoke with explained how being able to access this service had assisted them when they were at work and had saved them from having to attend a hospital Accident & Emergency Department.

Smoking status and advice about local smoking cessation services are routinely recorded and discussed with patients during GP consultations. General health promotional material was easily accessible to people of working age on the practice's website. Other advice and information for the working age population, such as out of hours services including minor injuries clinics were available on the practice's website.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Our findings

There were no barriers to accessing the services at the practice for any vulnerable group. The staff believed that patients could access the practice's services without prejudice. The practice had identified patients with learning disabilities. These patients had been offered an annual health check.

The practice was aware of and was providing services for people in vulnerable circumstances according to the demand they were familiar with. The practice area did not have a significant homeless population. We were informed that homeless people would be seen by a GP, should they present at the surgery. The practice had provided leaflets in their premises and similar information on their website about the out of hour's arrangements and the walk-in clinics and minor injuries clinics that served the area. This demonstrated that people in vulnerable circumstances had been considered and informed so that they could access health care services and receive appropriate treatment.

The practice had identified patients with a learning disability and had commenced the annual health reviews for these patients in July 2014.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Our findings

There was information on the practice website information relating to mental health and for support services such as the Samaritans, healthy living, Drinksense (a local service to reduce harm caused by alcohol and substance misuse) and counselling.

The practice held a register of its patients known to have poor mental health. Doctors recognised and managed referrals of more complex mental health problems to the appropriate specialist mental health services.

The practice had ensured that patients with a mental illness had been offered an annual physical health check and that their medication had been regularly reviewed in line with NICE guidelines and at other times when it was necessary. Smoking status and smoking cessation advice had been recorded and offered to patients.

The practice held a register of patients with dementia. These patients were offered a full annual health check and were included in the winter flu vaccination programme. We found that carers had frequently been included in the review process and were actively encouraged to participate. We also found that consent and capacity had been considered whenever reviews and consultations for patients with mental ill health had taken place.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **Patients were not protected against the risks associated with the management of medicines because the provider did not have appropriate arrangements in place for the recording, safe keeping, dispensing and disposal of medicines.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The provider had not, as far as was reasonably practicable, ensured that service users, staff and others were not at risk of a healthcare associated infection. There was no effective system in place to assess the risk of and to prevent, detect and control the spread of a health care associated infection and ensure the maintenance of appropriate standards of cleanliness and hygiene.**

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.