Thistlemoor Road Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Thistlemoor Surgery on 3 September 2015. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- The practice was actively involved in local and national initiatives to enhance the care offered to patients. They were proactive in trialling new ways of working to ensure they continued to meet the needs of the patients.
- Patients said they were treated in a way that they liked and they were involved in their care and decisions about their treatment. Information was provided in a range of formats and languages 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). Information about how to complain was available and easy to understand.
- There was a structured system for providing staff in all roles with annual appraisals of their work and planning their training needs.
- The practice undertook a wide range of both clinical and non clinical audits to drive improvements in patient care.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

- The practice had a clear vision that had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice offered a wide range of extended hour opening times, both early in the morning, the early evening and on Saturday mornings. The practice operated a walk in surgery each morning which meant that patients who attended between 8.30am and 10.30am were seen. Patients we spoke with particularly valued this walk-in service.
- Health care assistants were key members of the practice team and most spoke a range of languages, including those spoken by many of the practice's population group. This supported good communication and patients' involvement in understanding and managing their care.
- The practice offered health checks for 40-75 year olds. Despite already meeting its target to complete 300 of these for the year 2015-2016, it had decided to continue with these checks so that patients' health and well-being could be monitored.
- The practice offered smoking cessation clinics in different languages to meet the needs of its patients, many of whom did not have English as their first language. These clinics had been successful in helping 70% of those who had attended to give up smoking (56 patients in total).
- The practice's premises provided excellent facilities for patients. There was a resource room containing a range of health information for patients; a prayer room for use by both staff and patients; a room for mothers to breast feed their babies in private and two sound proof rooms where staff could telephone patients confidentially and without distraction.
- A local councillor told us that the practice was very engaged with local schools, inviting school parties to visit and talking to children about the work of doctors and nurses.

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?

Good 

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Patients were protected by the practice's safeguarding procedures and medicines were well managed.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs.

Are services caring?

Good 

The practice is rated as good for providing caring services. We observed a patient-centred culture and feedback from patients about their care and treatment was consistently positive. Data showed that patients rated the practice higher than others for several aspects of care. The organisation of the practice's reception services promoted patients' dignity and privacy. Information for patients about the services available was easy to understand and accessible, often in a range of languages. We also saw that staff treated patients with kindness and respect, and maintained their confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. The practice had excellent facilities and was well equipped to treat patients and meet their needs The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG).

Summary of findings

Appointment systems and clinics had been designed specifically to meet the needs of its diverse population group and offered patients easy access to services. Health care assistants had been recruited from the local population and they supported the wider practice team in understanding the language, background and cultures of the patients served by the practice.

Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for providing well-led services. The practice had an open and supportive leadership and a clear vision with quality, improvement and learning as its top priorities. The practice promoted high standards and staff took pride in delivering a quality and innovative service to its patients. The practice staff met regularly to review the delivery of care and the management of the practice. The practice took an active part in GP education and encouraged staff at all levels to develop their knowledge and skills.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. There are aspects of the practice which were outstanding and this related to all population groups Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people such as osteoporosis and coronary heart failure. The practice had achieved 100% of the available points in these areas that was above both the CCG and national averages. 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 home visits and rapid access appointments for those with enhanced needs. The practice identified patients with caring responsibilities and those who required additional support by recording this on their patient record.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. There are aspects of the practice which were outstanding and this related to all population groups. GP and nursing staff had lead roles in chronic disease management and had received additional training to do so. Patients at risk of hospital admission were identified and seen as a priority and longer appointments and home visits were available when needed. Patients were able to attend the surgery's 'open clinics' rather than going to A&E departments. Patients with long term conditions were offered a single appointment annual review to check that their health and medication needs were being met, rather than attending for repeat appointments. QOF data showed the practice consistently performed well above the CCG and England average in relation to long term conditions management, such as asthma and chronic obstructive pulmonary disease. Patients who had more complex needs, or whose condition was life limiting, were regularly discussed at multi-disciplinary team meetings and had care plans put in place.

Families, children and young people

Outstanding ☆

The practice is rated as outstanding for the care of families, children and young people. There are aspects of the practice which were outstanding and this related to all population groups. There are aspects of the practice which were outstanding and this related to

Summary of findings

all population groups. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

The practice provided a full family planning service including the fitting of contraceptive devices. Women taking the contraceptive pill were invited to attend the practice each year for a yearly 'pill check' and to discuss long-term contraception.

Appointments were available outside of school hours and the premises were suitable for children and babies. Health visiting and midwife services were available on site.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working-age people (including those recently retired and students). There are aspects of the practice which were outstanding and this related to all population groups.

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. For example, appointments were available in the early morning and in the evening or on Saturday mornings. Appointments, prescriptions and registration were all available on line which improved access for working patients. The practice was proactive in offering a full range of health promotion and screening that reflected the needs for this age group for example travel vaccinations, family planning and health screening.

People whose circumstances may make them vulnerable

Outstanding ☆

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. There are aspects of the practice which were outstanding and this related to all population groups

The practice held a register of patients living in vulnerable circumstances including looked after children, vulnerable adults and children and those with a learning disability. It offered longer appointments for people with a learning disability or those who required them. 65% of people with a learning disability had received a health check in the year 2014-2015.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff supported vulnerable patients to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and had received additional training

Summary of findings

for this. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of normal working hours.

The practice provided care for around 11,000 patients who did not speak English as a first language. Health care assistants working at the practice routinely provided face to face translation services for patients during consultations. This meant that non English speaking patients received a highly effective, personalised and timely service which is outstanding.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia). There are aspects of the practice which were outstanding and this related to all population groups.

People experiencing poor mental health had been offered an annual physical health check and psychological therapies and the local mental health service were accessible at the practice. All staff had received training on the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and were able to explain their role in relation to this. The practice proactively identified patients who might be at risk of developing dementia. Patients experiencing poor mental health and those with dementia had a named GP to ensure continuity of care and a single point of contact for other agencies when discussing their care needs.

Summary of findings

What people who use the service say

The national GP patient survey results published in July 2015 showed the practice was mostly performing in line with, or above, local and national averages. There were 98 responses giving a response rate of 21%.

- 80% find it easy to get through to this surgery by phone compared with a CCG average of 76% and a national average of 74%.
- 88% find the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 80% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 99% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 85% describe their experience of making an appointment as good compared with a CCG average of 77% and a national average of 74%.
- 45% feel they don't normally have to wait too long to be seen compared with a CCG average of 60% and a national average of 58%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards that were all positive about the standard of care received, the cleanliness of the practice and the helpfulness of the staff. Patients particularly valued the fact that they could talk to the practice's staff in their own language and the open surgery hours that allowed them to see a GP without having to make an appointment first.

We spoke with 11 patients during our inspection who all spoke positively about the service they received. They praised the practice's phlebotomy service, stating they always received their blood test results back quickly, usually within 24 hours. Patients also appreciated the help they had received in order to register at the practice. Patients told us it was easy to get through on the phone, even on a Monday morning when the practice was especially busy.

We interviewed six members of the PPG who told us that the practice's staff listened to them and acted on their suggestions. They reported that they had good working relationships with the staff, especially the registered manager, Dr Neil Modha,

A local councillor told us that the practice was very engaged with local schools, inviting school parties to visits and talking to children about the work of doctors and nurses. He reported that the practice had adapted its services well to meet the changing demographic of its practice population.

Outstanding practice

- The practice offered a wide range of extended hour opening times, both early in the morning, the early evening and on Saturday mornings. The practice operated a walk in surgery each morning which meant that patients who attended between 8.30am and 10.30am were seen. Patients we spoke with particularly valued this walk-in service.
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Thistlemoor Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser a second CQC inspector, a practice manager specialist adviser and an Expert by Experience.

Background to Thistlemoor Road Surgery

Thistlemoor Medical Centre is sited in a residential area close to the city centre of Peterborough. It serves approximately 17,900 registered patients and has a general medical services contract with Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

Compared with other practices in the area, it has the highest proportion of patients under the age of 18 and the lowest proportion of patients over the age of 65. It has a more deprived population than the CCG area average and the England average. Specifically, the area has greater income deprivation affecting children and older people than the CCG and England averages. The practice serves a diverse population with the majority of patients coming from eastern European countries such as Poland, Lithuania, Russia and the Czech Republic. These patients total more than 11,000, for whom English is not their first language.

The practice consists of eight GPs, five nurses and 15 health care assistants. They are supported by a full time practice manager and twelve reception/administrative staff. The practice offers placements to medical students from Imperial College and Cambridge University, as well as doctors preparing to be General Practitioners. Health visitors and district nurses employed by other providers within the NHS are also based in the practice building.

The practice is open between 8.30am and 6.30pm Monday to Friday. Extended hours surgeries are offered between 7am-8am on weekdays, and from 8am to10 am on Saturdays. The practice is open late on a Wednesday evening until 8pm. There is walk in surgery system in the mornings between 8.30 am and 10.30 am where patients are able to turn up the practice without a booked appointment and can wait to see a clinician.

Thistlemoor Medical Centre has opted out of providing out of hours services to its patients. These are operated by another provider in Peterborough and their details are given on the practice website and in their leaflets.

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.

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 theCare Act 2014.

Detailed findings

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.

How we carried out this 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 visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit 3 September 2015. During our visit we spoke with a range of staff including GPs, nurses, health care assistants and administrative staff. We also spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record and learning

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. The practice carried out an analysis of all significant events. We viewed the practice's significant events log for the six months prior to out inspection and found evidence that all events had been recorded, discussed with the relevant staff and any learning from them clearly documented and shared. Minutes from the practice's clinical meeting of 24 August 2015 demonstrated that recent complaints and incidents had been discussed with those present. A review of all the complaints received since August 2014 had been undertaken by the practice. Common themes had been identified and the practice had responded by increasing its capacity for emergency appointments and organising training for staff around customer care.

National patient safety alerts were disseminated to staff via email and two of the practice's senior clinicians were responsible for ensuring that any action required in their light was implemented. However, we found that, whilst there was a system in place to disseminate and action Medicines & Healthcare products Regulatory Agency alerts, the practice had missed two recent alerts. We found that the practice had responded appropriately to alerts in relation to sodium valproate and pregablin, however it could not demonstrate to us it had responded to alerts about the medicines hydroxyzine and ibuprofen. We outlined the potential risks to patients as part of our inspection feedback and the practice took immediate action to remedy the oversight.

Reliable safety systems and processes including safeguarding

Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation, and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There were lead members of staff for safeguarding including the practice's senior GP and nurse. The lead GP told us she had recently attended a safeguarding leads conference in May 2015 and also received quarterly safeguarding e-newsletters that she distributed to staff. She told us she had sent recent guidance in relation to grooming and domestic violence.

The practice manager told us that the police had come to talk to practice staff about their work in relation to tackling the grooming of young people in the area and this had helped highlight the issue to them. On the day of our inspection, trainers from Cambridgeshire's safeguarding team were on site to deliver training to staff.

Staff demonstrated they understood their responsibilities and all had received appropriate safeguarding training relevant to their role. They were able to give us specific examples of how they had worked with local agencies to protect patients. One health visitor told us that practice staff took safeguarding concerns seriously and that one of the practice's GPs acted swiftly in response to an issues of domestic violence that she had reported to her.

The practice kept registers of both vulnerable adults and children and specific administrative staff had responsibility for ensuring it remained accurate and up to date, and that patients had been coded correctly. We viewed minutes of the practice's weekly clinical meetings and saw that patients with safeguarding concerns were regularly discussed to ensure a consistent approach to their care by staff. One of the practice's GPs regularly reviewed all A&E discharges and checked for any children under the age of 12 years who had experienced a fracture.

The practice had completed the Royal College of General Practitioner's child safeguarding audit in September 2014, and again in August 2015. As a result it had implemented polices in relation to domestic violence and also female genital mutilation. We noted good information in patient waiting areas about domestic violence and female genital mutilation with details of organisation to contact for support.

Notices were displayed in the waiting areas, advising patients that they could request a chaperone. There was also information about the chaperone service on the practice's website. All staff who acted as chaperones were trained for the role and had received a disclosure and

barring check (DBS). 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.

There were procedures in place for monitoring and managing risks to patient and staff safety. The practice had up to date fire risk assessments and regular fire drills were carried out. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella.

The practice used CCTV cameras to improve security in the building. These were placed in communal areas only such as patient waiting areas, exits and entrances, and the car park. We noted information posters in these areas informing patients of their use and who to contact should they have any questions. All footage taken was destroyed after a period of two weeks.

Medicines management

The practice had comprehensive policies and procedures relevant to the safe management of medicines and prescribing practice.

We checked medicines stored in two treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Records showed that fridge temperature checks were undertaken to ensure 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. Blank prescription forms were kept securely and a spreadsheet was in place to track their use.

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. Appropriate action was taken based on the results.

The practice regularly reviewed its prescribing rates and we viewed summaries of audits completed for antibiotic, oral contraceptive and warfarin prescribing. The practice's antibiotic prescribing rates were low when compared to the local clinical commissioning group's figures for antibiotics.

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 saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD. The practice had supported one of its nurses to become an independent nurse prescriber, allowing them to prescribe a range of medicines to patients.

Cleanliness and infection control

The practice had suitable infection control policies and procedures in place which covered a wide range of areas including hand hygiene, vaccine storage and handling specimens. Training records we viewed showed that all staff had received training in infection control and also hand washing techniques.

The practice employed its own cleaners and we viewed detailed daily, weekly and monthly task sheets for them to complete. As many of the cleaners did not have English as their first language cleaning instructions had been translated into different languages so they could understand them. One of the practice's senior reception staff undertook weekly cleanliness checks to ensure standards were maintained.

We observed that all areas of the practice were visibly clean and hygienic, including the waiting areas, corridors, meeting rooms and treatment rooms. The patient toilets were clean and contained liquid soap and paper towels so that people could wash their hands hygienically. We checked three treatment rooms and surfaces including walls, floors and cupboard doors were free from dust and visible dirt. The rooms had sealed flooring and sealed work surfaces so they could be cleaned easily. There were prompter posters above each sink reminding staff of the correct way to wash their hands. We saw that sharps boxes had been assembled correctly and were wall mounted to ensure their safety. There were foot operated bins in each room to reduce the risk of cross infection.

The practice conducted its own comprehensive infection control audits every six months, evidence of which we viewed. Infection rates following minor surgery were monitored closely and the most recent audit covering April 2014-2015 showed there had been no infections.

Equipment

Staff told us the practice was well equipped and requests for repairs or replacement equipment were dealt with

Good

Are services safe?

swiftly. All equipment was tested and maintained regularly and we saw maintenance logs and other records that confirmed this. We saw evidence of the calibration and service of relevant equipment; for example weighing scales, spirometers, pulse oximeters and nebulisers.

Staffing and recruitment

The practice had detailed recruitment policies that set out the standards it followed when recruiting both clinical and non-clinical staff. Staff personnel files we looked at contained evidence that appropriate recruitment checks had been undertaken prior to their employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. However, we noted that the recruitment risk assessment for one staff member was not robust, and contained conflicting personal information about the employee.

We spoke with two newly recruited members of administrative staff. They told us they had received a full induction to their role that they had found useful. They reported that their competence to undertake a range of tasks had been fully assessed to ensure they were completing them correctly. One of the nurses reported that as part of her induction she had spent four weeks working directly alongside one the GPs. Something she had never experienced before when starting a new job and valued greatly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies and there was an on-call GP on duty throughout the day. Records showed that all staff had received training in basic life support. Emergency equipment including five anaphylaxis kits, oxygen and automated external defibrillators (used in cardiac emergencies) were available throughout the practice. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We saw that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff and all staff knew of their location. Processes were also in place to check that emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

An emergency panic button was available in treatment rooms so that clinicians could summon assistance in an emergency

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. Although NICE guidelines were not formally disseminated to clinicians, they were discussed at the weekly clinical meetings so that clinicians were kept up to date. We viewed minutes of the meetings for the last year which showed that a range of issues was discussed including latest NICE guidance, clinical protocols, local health services and treatment referral pathways. One nurse told us she found these meetings useful as she could discuss complex cases with colleagues and get good advice about how best to manage them.

The practice monitored that NICE guidelines were followed through a range of audits and we viewed these for antimicrobial prescribing and diabetes management. The practice also used a Pathfinder system which included both local and national guidance about care pathways and referral processes for patients. One GP told us that using this system ensured they were following best clinical practice and allowed them to apply clinical thresholds consistently.

The practice had identified 250 of its patients with the highest level of need who were most likely to require urgent medical assistance or have an unplanned hospital admission. The practice confirmed that they had developed personalised care plans to improve the quality and co-ordination of care for these patients. The practice had also been pro-active in identifying patients with potential dementia and had improved its dementia detection rates from 56% to 75% because of this screening.

Management, monitoring and improving outcomes for people

The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance. This is a system intended to improve the quality of general practice and reward good practice). Specific staff were responsible for overseeing the practice's QOF performance and we saw that QOF data was discussed at practice meetings. We found that effective action had been taken to address areas of low performance such as diabetes management. Figures given to us by the practice indicated that it had achieved 100% of the total number of points available for 2014/15, and had improved its performance from the previous year. Staff told us they had achieved good QOF results because of their proactive assessment and recall arrangements which ensured patients who needed to be reviewed were seen.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been six clinical audits completed in the last year, including those for diabetes management and oral contraceptive prescribing. All of these were completed audits where the improvements made had been implemented and monitored. The practice had a clinical audit plan in place for 2015-2016.

A good range of audits were also completed to drive improvements in patient care and we viewed audit summaries of the practice's safeguarding procedures, its infection control measures, its minor surgery infection rates and dementia prevalence rates.

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 showed the practice had outcomes that were good in relation to A&E attendances and referral rates.

The practice had identified patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. Emergency hospital admission rates for the practice were relatively low compared to the national average.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice had a strong working relationship with the community teams including the district nurses, health visitors, midwives, and community psychiatric nurses,

some of whom were based on site. Patients had access to a mental health gateway worker and also a range of counselling services. One health visitor told us she worked well with the practice's staff and complimented the GPs on their work with mothers suffering from depression.

Effective staffing

We found staff to be knowledgeable and experienced for their roles. Training records we viewed showed that clinicians had undertaken a wide range of training including coil fitting, minor injury, cervical screening and wound management; as well as training in a number of long terms conditions. Three of the doctors had postgraduate certificates in teaching medical education. The practice manager held a Masters Degree in Business Administration and attended meetings with other practice managers in the areas to share good practice

The practice had a very good skills mix which included an advanced nurse practitioner who was able to see a broader range of patients than the practice nurses. The GPs led in specialist clinical areas such as mental health, gynaecology, dermatology and minor surgery. The practice's health care assistants had received a good level of training and were able to undertake blood pressure and pulse measurements, ECGs, vaccination administration, healthy living screening, smoking cessation and ear irrigation. Senior clinicians within the practice carefully assessed and monitored the health care assistants' clinical skills.

Staff told us they had good access to training and were well supported to undertake further development in relation to their role. This included ongoing support during sessions, one-to-one meetings, training afternoons, clinical supervision and support for the revalidation of doctors. The practice's GP trainer provided training sessions to the nursing team every Wednesday afternoon and there was protected learning time on a Thursday afternoon for all staff.

There was a structured system for providing staff in all roles with annual appraisals of their work and for planning their training needs. Staff we spoke with told us they found their appraisal useful as it allowed them to reflect on their achievements and also parts of the job they found difficult.

We found that where poor staff performance had been identified appropriate action had been taken to manage this quickly and effectively.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. All relevant information was shared with other services in a timely way, for example when people were referred to other services.

The practice had access to both an urgent care and a palliative care clinical dashboard, allowing clinicians to view unscheduled attendances at local health care settings such as hospitals and out of hours services. One of the GPs told us that this dashboard helped in the proactive management of patients following an admission to hospital.

The practice held multidisciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions and those with end of life care needs. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as needed.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, and their duties in fulfilling it. A training session for staff on the mental capacity, deprivation of liberty and safeguarding took place for staff on the afternoon of our inspection to ensure they were up to date with the latest guidance.

All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their work. For example, one nurse showed in-depth understanding of the consent issues involved in giving a patient with severe disabilities a smear test. She also showed a good awareness of the importance of gaining the correct parental consent when giving children their vaccinations.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence. This helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

The practice used written patient consent forms for all minor surgery, joint injections, coils and implants.

Health promotion and prevention

Patients were supported to live healthier lives in a number of ways. The practice had an informative website which provided information about a wide range of health and care topics and there were leaflets in the waiting rooms, giving patients information on a range of medical conditions. There was also a specific resource room which patients could visit to research medical conditions and treatments.

All new patients registering with the practice were given a health check as part of their registration process. The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. It had a target to complete 300 of these checks for the forthcoming year but had already achieved this within the first two months. Despite already meeting its target, the practice had decided to continue with these health checks in order to better monitor patients' health and wellbeing.

The practice had a number of staff trained in smoking cessation, and three smoking cessation clinics were held each week. Staff who spoke different languages offered these clinics so that patients could attend one provided in a language they could understand. These clinics had been effective in helping 70% (56 patients) of those attending to give up smoking.

The practice also offered health checks for patients with a learning disability and had provided health checks for 65% of these patients. The practice used the Cardiff Health Check for People with a Learning Disability- a recognised and comprehensive tool to assess the health care needs of this group.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 84%, which was comparable to the national average of 82%.

Childhood immunisation rates for the vaccinations given were lower when compared to CCG averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 64.8% to 90.7% and five year olds from 54.3% to 85.5%. However, the figures were low as many of the practice's children transitioned between different countries or left the UK for significant periods of time. Flu vaccination rates for the over 65s were 70.39%, and at risk groups 65.88% which were comparable to national averages.

The practice provided a full family planning service including the fitting of contraceptive devices. Women taking the contraceptive pill were invited to attend the practice each year for a yearly 'pill check' and to discuss long-term contraception.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Feedback from the 21 comment cards we received was very positive about the way patients were treated by the practice's staff. Respondents told us that staff were caring and professional, and took their health concerns seriously. Patients reported they particularly valued the fact that they could communicate with staff in their own language.

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone. Doctors and health care assistants called patients to treatment rooms personally and this was done in a cheerful and polite manner.

There were two sound proofed rooms available in which staff could receive and make telephone calls. These rooms were separate from the main reception area, allowing staff to contact patients in privacy and without distraction. The practice had a separate registration room, where patients could be assisted to complete registration forms in private. The practice also offered patients a multi- faith prayer room and a room where mothers could breast-feed their babies in private.

Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Results from the national GP patient survey showed patients were happy with how they were treated. The practice was in line with local and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 92% said the GP was good at listening to them compared to the CCG average of 89% and national average of 86%.
- 92% said the GP gave them enough time compared to the CCG average of 87% and national average of 87%.
- 94 % said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 94%
- 83% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 85%.
- 80% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and national average of 90%.
- 88% patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

However, results from the national GP patient survey in July 2015 we reviewed showed that the practice scored slightly lower than the local and national averages when patients were asked about their involvement in planning and making decisions about their care and treatment

For example:

- 76% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and national average of 86%.
- 75% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 82% and national average of 81%
- 82%said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 90 % and national average of 90%

The practice's website contained its clinical protocols for long-term condition management, giving patients access to comprehensive information about what treatment they could expect and how their medical needs would be met.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. The practice's website gave a full listing of all the support and

Good

Are services caring?

advocacy agencies available in Peterborough including mental health groups, bereavement services and carers' groups. A number of mental health and counselling services were based on site at the practice.

Patients with caring responsibilities were encouraged to identify themselves to the practice team so that they could be offered additional support if they needed it. We viewed carers' registration forms on the reception desk. These forms included information about the local carers' services and how to request a carers' assessment. The practice's computer system alerted GPs if a patient was also a carer and so could be offered a flu vaccination. 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.

Family member of patients who had died receive a condolence card from the practice and also the offer of further support if required.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. One of the practice's partners was a member of the local commissioning group.

Aspects of the service had been specifically designed to meet the needs of its diverse patient population, 11.000 of whom did not have English as a first language. Many of the staff were multi-lingual, reflecting the languages used by many of the practice's patients. Doctors were able to speak a number of languages including Urdu, Gujerati and Punjabi. Health care assistants could speak a range of eastern European languages including Polish, Czech, Russian and Lithuanian. There was a multi-lingual electronic booking in system and information leaflets about the practice could be downloaded from its website in Polish and Lithuanian. The practice had access to translation services if needed. Considerable effort went into matching patients with a GP or health care assistant who spoke the same language when booking them appointments.

The practice offered a wide range of services to patients in addition to chronic disease management including well person checks, NHS health checks, family planning (including contraceptive implants and coils), minor surgery, phlebotomy, smoking cessation, joint injections, counselling services and yellow fever vaccinations. District nursing, health vising and midwifery services were also based on the premises. The practice also hosted other services that delivered endoscopy, colonoscopy and ultrasound scanning services.

The practice offered extended opening hours for patients who could not attend during normal opening hours. There were longer appointments available for people with a learning disability and home visits for those who found it difficult to attend.

Access to the service

The practice was centrally located and within easy reach of bus stops. There was a large car park to the rear of the surgery with space for 140 cars. A pharmacy was located next door to the practice.

Comprehensive information was available to patients about appointments on the practice's website and in its patient information leaflet. This included surgery times, how to book appointments through the website and how to cancel appointments**.** Patients were provided with a range of flexible and accessible appointment times. The surgery was open from 8:30am to 6:30pm Monday to Friday. There was a walk in surgery system in the mornings between 8.30am and 10.30am when patients were able to turn up at the practice without a booked appointment and wait to see a clinician. Extended hours surgeries were offered between 7am-8am on weekdays, and from 8am to10 am on Saturdays. The practice was also open late on a Wednesday evening until 8pm.

Results from the national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages. For example:

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 76%.
- 80% of patients said they could get through easily to the surgery by phone compared to the CCG average of 80% and national average of 75%.
- 85 % patients described their experience of making an appointment as good compared to the CCG average of 77% and national average of 74%.

The practice was proactive in offering online appointment booking services. A text service was available to remind patients of their appointment and patients could order their repeat prescriptions in person, by telephone, online or by post. The practice was about to introduce electronic prescriptions and from November 2015 patients would be able to choose to have their prescription sent to a pharmacy of their choice so they did not need to go to the practice to collect it.

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

The premises had been designed to meet the needs of patients with disabilities. There were disabled car spaces available in its car park and wheelchair access through its

main entrance. The practice's reception desk had been lowered to enable better communication with wheelchair users. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There were large waiting areas with plenty of space for wheelchairs and prams. Hearing induction loops were also available. The practice had its own wheelchairs on the premises for patients to use if needed. The nurses and GPs regularly visited patients at home if their health or mobility meant they were unable to attend appointments.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system with good information available in the waiting area and on the practice's web site. The practice's patient information leaflet gave the name of the person responsible for managing complaints and also the address of NHS England for patients who did not want to contact the practice directly. There was a complaints and suggestions box displayed prominently in the reception area. Details of the complaints procedure were available in each of the treatment rooms we checked. Reception staff spoke knowledgeably about how to manage complaints and the practice's procedure.

Minutes of the practice's meetings we reviewed showed that patients' complaints were regularly discussed so that learning from them could be shared. The practice also reviewed complaints to detect themes or trends. At the clinical meeting of 24 August 2015, a review of all written complaints and incidents had taken place. We viewed minutes of another meeting where staff had received training in complaints handling to ensure they did this effectively. Complaints received by the practice were also shared with members of the patient participation group.

We looked at four recent complaints received and found that these had been dealt with in a timely, open and transparent way. Lessons had been learned and action had been taken as a result to improve the quality of care. For example, following issues resulting from a minor procedure, the practice had improved its information to patients about the procedure and symptoms to look out for. Following a complaint received from a local hospital, a specific meeting had been held to remind staff about the need to book interpreters when referring patients for appointments.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found the practice's vision and values were clearly outlined in their Statement of Purpose and on their website. Its vision was to become a health and well-being village and, at the time of our inspection, it was extending its premises to accommodate dental and chiropody services for the local community. The practice's website contained details of the Patients' Charter that outlined what patients could expect from the practice.

From our interviews with staff at all levels during our inspection, we found that the practice vision and aims formed the basis of their day to day work, and the practice was run by a patient centred team, who were committed and proud of the work they did.

Governance arrangements

There was an established leadership structure with clear allocation of responsibilities amongst the GPs, practice manager and the practice staff. There were clearly identified roles within the practice for both clinical and administrative areas. For example, there were clinical leads for mental health, minor surgery and gynaecology; and administrative leads for QOF monitoring, audio typing, clinical administration and reception. 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. There were weekly clinical meetings where complex cases, safeguarding issues, NICE guidelines and new services were discussed. There were monthly health care assistant meetings where QOF performance, staff training needs and the organisation of clinics were discussed, and whole practice meetings were held every three months. Staff spent time together outside practice hours to help them build and develop their relationships as a team. The partners held social events involving the whole practice team, including dinners and Christmas parties.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice's computer systems. Staff had signed the policies to indicate that they had read, understood and agreed to abide by them. We looked at 10 policies and procedures and found that they were up to date and had been reviewed regularly.

The practice also had an on-going programme of both clinical and non-clinical audits that it used to monitor quality and systems to identify where action should be taken. For example, we saw that audits had been completed to evaluate: antibiotic prescribing, the effectiveness of diabetic test strips, its child safeguarding procedures and its infection control measures. The senior clinical health care assistant undertook regular spot checks of patients' records to ensure they were receiving the correct care.

All the staff we spoke with felt supported by the practice and reported that they were encouraged to develop their knowledge and skills. All staff had protected learning time, where the practice closed for an afternoon to engage in a range of educational and training events. A number of staff commented on the excellent teaching skills of the practice's GP trainer.

Leadership, openness and transparency

The practice had well organised management arrangements to support the GP partners in the running of the practice. Staff told us the practice was well-led, citing effective management, good team working, efficient systems and access to training as the main reasons**.** Newer members of staff spoke of having good quality inductions, training and support to help them in their new roles.

One of the nurses particularly valued what she described as the 'flat' hierarchical structure within the practice, demonstrated by the fact that she shared an office with one of its partners.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings. Minutes of all the meetings we reviewed showed that information about the practice and any challenges it faced were shared openly with staff, and that staff were actively consulted about changes to the practice.

There was a strong focus on continuous learning and improvement at all levels within the practice.

We found that the partners were very aware of the value of education and effective skill mix, not only for the GPs, but for members of all staff groups within the practice. Staff

Are services well-led?

Outstanding ☆

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

were supported and encouraged to develop within and beyond their roles. For example, many of the practice's staff had originally joined the practice in administrative and receptions roles, but had been supported and trained to become health care assistants. The practice was sponsoring some of these health care assistants to become nurses. One the nurses had been supported to become an independent nurse prescriber.

The practice was open and transparent about how it operated and a number of its policies, and protocols for managing chronic disease were available on its websites for patients to view. There was also good information about how patients could access their medical records.

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

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and complaints received. For example, in response to patient feedback the practice had improved its car parking facilities; increased patients' access to information relating to self-care and had created a more homely environment within the premises. An action plan to improve the service further had been developed with the PPG for the forthcoming year which included improving the practice's telephone system and recruiting more doctors and nurses.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One health care assistant told us that their suggestion to hold chronic disease management clinics in the afternoon, in addition to the mornings, had been listened to by the partners, and implemented as a result.

The practice had introduced the NHS Friends and Family test as another way for patients to let them know how well they were doing. Results of these were shared at staff meetings. Results of the national GP survey were also monitored closely. The practice had undertaken comparison of its GP survey results between 2012 and 2015 and had noted considerable improvement in its overall scores.

Innovation

A partner GP had observed a model of training healthcare assistants to undertake some tasks traditionally undertaken by GPs and nurses in the USA and had recognised the potential of the model to increase services for patients. The GPs had developed their use of healthcare assistants at the practice along this model and found that it enabled them to increase the number of patients seen and the level of service provided. This way of working had been reviewed by Sheffield University and found to be both safe and popular with patients.

The practice pro-actively recruited health care assistants who could speak several languages so that they could communicate effectively with patients and offer translation services on site for the GPs.

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the Peterborough area had been selected as a Prime Minister's Challenge fund area and the practice was involved in the implementation of a service to deliver extra appointments between 8am and 8pm.

The practice was planning to introduce 'Web GP' in December 2015, allowing patients to consult their GP via e-consultations on-line.

A local councillor told us that the practice was very engaged with local schools, inviting school parties to visits and talking to children about the work of doctors and nurses.