Brunston&Lydbrook Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brunston & Lydbrook Practice on 14 January 2015.

We rated the practice as good for providing well-led, effective, safe, caring and responsive services. It was also good for providing services for older people, people with long-term conditions, mothers, babies, children and young people, working-age population and those recently retired people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and knew how to report incidents and near misses. Information about safety measures were recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients told us they were treated with dignity and respect and they were involved in their care and decisions about their treatment.
- Information about the services provided and how to complain was available and easy to understand.
- The practice had good facilities and was equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted upon.

However, there were also areas of practice where the provider should make improvements.

- There should be monitoring of the dispensary room temperature where medicines were stored to ensure they were kept within the manufacturers recommended temperature ranges.

Summary of findings

- Methods of monitoring blank FP10 prescriptions for printers were not in accordance with national guidance as there was no process for logging which printers they were assigned to.
- The practice should use a recognised approved systems for equipment for cleaning.

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 report incidents and near misses. Lessons were learned from incidents and complaints and communicated to staff and actions were put in place in order to prevent reoccurrence. Information about safety measures were recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Information from NHS England, the Clinical Commissioning Group and the practice showed that patient outcomes were average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and treatment and support was planned and delivered to meet those needs. Care plans were in place for patients who had long term care or complex health needs. For patients deemed to be at a higher risk in respect of their ability to make decisions we found that there were systems in place for assessing capacity and decision making that involved their designated carer or next of kin. The practice provided advice and support on health promotion. Staff had received training appropriate to their roles and any further training needs had been identified and training planned in order to meet these needs. There was evidence of regular appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with dignity and respect and they were involved in decisions about their care and treatment. There was support provided to patients and carers to enable them to cope emotionally with their care and treatment. We also saw that staff treated patients with kindness and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment and there was continuity of care, with urgent appointments available the same

Summary of findings

day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly and appropriately to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff understood and supported the ethos of the practice. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and had attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Just above 12% of the patient population were over 65 years old. Around 6.5% of the were 75-84 years old and 2.7% of patients were over 85 years old. The practice offered proactive, personalised care to meet the needs of the older people in its population. Each patient was provided with a named GP for the over 75 year olds. They also had personalised, individual care plans for all of the patients over the age of 75 years. There was multidisciplinary team working to support patients to remain being cared for in the community and prevent hospital admissions.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Information from NHS England showed that 59.5% of the patients had long standing health conditions, which was above the national average of 54%. Nursing staff had been encouraged to develop lead roles in chronic disease management. Patients at risk were provided with support from multidisciplinary team working with other professionals. Care plans were in place to prevent hospital admissions. All these patients had at least an annual review to check that their health and medication needs were being met.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children who were at risk. Last year's performance for all immunisations was either above average or slightly below for the CCG. The practice staff were able to offer immunisations at the convenience of the patients/ patient's families and not just at set clinic times.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). Of the practice population 31.14% were aged from 45 to 64 years old. Of the working population 1.4% were unemployed which is below the national average of 6.2%. The practice offered on line services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability and annual health checks were offered to provide extra support to them. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people or people seen as at risk. The practice provided access to and information about various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies. The percentage of patients who had caring responsibilities was just under 13% which is below the national average of 18.5%. The practice was in the process of implementing systems to monitor and support patients who had caring responsibilities.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). Patients with poor mental health were offered an annual physical health check. The practice staff worked regularly with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia, and had care plans in place. Patients had access to a visiting mental health worker at the practice.

Summary of findings

What people who use the service say

We spoke with six patients in person during the inspection visit. We received information from the 25 comment cards left at the practice premises.

Patients told us they were always able to obtain an appointment, were seen in good time and didn't feel rushed in their appointments. Staff were friendly and approachable and they had very positive experiences of care and support from the practice and the staff. We were told staff treated patients with dignity and respect and patients had found the staff helpful and caring.

Patients said they felt they were listened to and taken seriously with appropriate care and advice being offered. When we spoke with patients it was evident if they decided to decline treatment or a care plan this was listened to and acted upon.

Patients said the prescription service was quick and managed well, staff friendly and helpful.

Patients said they had found the practice clean, tidy and comfortable. Patients had commented they had found the practice environment hygienic and had no concerns about infection control.

Areas for improvement

Action the service SHOULD take to improve

- There should be monitoring of the dispensary room temperature where medicines were stored to ensure they were kept within the manufacturers recommended temperature ranges.
- Methods of monitoring blank FP10 prescriptions for printers were not in accordance with national guidance as there was no process for logging which printers they were assigned to.
- The practice should use a recognised approved systems for equipment for cleaning.

Brunston&Lydbrook Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and GP Specialist Advisor. The team also included a CQC Pharmacy inspector and a Practice Manager Specialist Advisor.

Background to Brunston&Lydbrook Practice

Brunston & Lydbrook Practice is situated in the market town of Cinderhill in a rural area of The Forest of Dean in Gloucestershire. The practice is one of two locations the provider has, the second practice is in Lydbrook five miles away. The practice has 5,700 registered patients. The practice provides care and support to patients from the surrounding areas and based on information from NHS England, 0.6% of its patients live in nursing homes.

The practice is located in purpose built premises over two levels. Brunston & Lydbrook Practice has a central patient waiting and reception area with consulting and treatment rooms accessible from this area. The first floor of the building is used for administration and storage purposes. The practice has a general medical service contract with NHS England. The GP practice is a dispensing practice.

Brunston & Lydbrook is only provided from one location:

Brunston Surgery

Cinderhill

Coleford

Gloucester

GL16 8HJ

The practice supports patients from all of the population groups which are older people; people with long-term conditions; mothers, babies, children and young people; working-age population and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 31% of patients registered with the practice were working age from 15 to 44 years; 31.14% were aged from 45 to 64 years old. Just above 12% were over 65 years old. Around 6.5% of the practice patients were 75-84 years old and 2.7% of patients were over 85 years old. 16% patients were less than 14 years of age. Information from NHS England showed that 59.5% of the patients had long standing health conditions, which was above the national average of 54%. The percentage of patients who had caring responsibilities was just under 13% which is below the national average of 18.5%. Of the working population 1.4% were unemployed which is below the national average of 6.2%.

The practice consisted of two GP partner posts, with one partner post currently vacant. The partnership employed two salaried GPs. There were two male and two female GPs. There were three practice nurses, two phlebotomists (obtaining blood samples for testing) and five dispensary staff. A practice manager, deputy practice manager and a team of administration staff worked across the two practice locations owned by the GP partnership. The practice reception was open from 8.30am-6.pm five days per week. Each day emergency appointments were available between 8am-8.30am, 1pm-2pm and 6pm-6.30pm. Routine appointments were available from 8am-1pm and 2pm-6pm.

The practice referred patients to NHS 111 for all out of hour's service to deal with any urgent patient requests when the practice was closed.

Detailed findings

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.

This provider had not been inspected before and that was why we included them.

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

The practice provided us with information to review before we carried out an inspection visit. We used this, in addition to information from their public website. We obtained information from other organisations, such as the local Healthwatch, the Gloucester Commissioning Group (CCG), and the local NHS England team. We looked at recent information left by patients on the NHS Choices website.

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

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

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

- 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.

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 on 14 January 2015. During our visit we spoke with three of the GPs, one practice nurse, and a dispensary assistant. We also spoke with the practice manager and the reception and administration staff on duty. We spoke with six patients and one temporary patient in person during the day. We received information from the 25 CQC comment cards left at the practice. We spoke to the manager of a residential care service whose service users were patients at the practice.

On the day of our inspection we observed how the practice was run, such as the interactions between patients, carers and staff and the overall patient experience.

Good

Are services safe?

Our findings

Safe track record

We spoke with three GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about seven events which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These included two cases of missed diagnosis and a wrong medication dosage prescribed.

Where events needed to be raised externally, such as with other providers or providing information for other relevant bodies, this was done promptly and appropriately. For example, providing information to the coroner.

National patient safety alerts (NSPA) and other safety guidance was checked and circulated to the relevant staff. There was a system of meetings where new information was discussed and plans put in place to ensure changes were made to the service where required.

The practice manager told us how comments, complaints and compliments received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing and other relevant staff. Significant events were reviewed and discussed at partner and practice meetings. There was a system of logging and monitoring the overall investigation and outcomes of significant events. When we spoke with staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff.

We saw from summaries of the analysis of the significant events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, the practice staff had identified a gap in the way blood test result delegation was dealt with and they amended the system to make it safe.

Safety alerts were circulated and information was made available on the electronic records for staff to readily access.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. Practice training records showed there was a programme of regular updates for training. There was information that showed non-clinical staff at the practice had been provided with or were in the process of completing level one training for both safeguarding vulnerable adults and children via e learning. Practice nurses and the practice manager had undertaken level 2 training which is recognised as best practice. All three GPs had received training for safeguarding vulnerable adults and been trained to level three for safeguarding children in line with national guidance.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities. Staff knew how to share and record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. One GP took the lead for safeguarding children and another for safeguarding adults at the practice. All staff we spoke to were aware who the leads were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern when the leads were not present.

The GPs we spoke with were able to give examples of how they had managed and responded to concerns raised. The practice carried out regular safeguarding meetings, the last carried out on 12 December 2015. The next update meeting for child protection was planned for the end of January 2015. The GPs demonstrated good liaison with partner agencies and they participated in multi-agency working, such as working with health visitors and school nurses. GPs attended quarterly safeguarding meetings with Gloucester Clinical Commission Group (CCG). We were told the local paediatric safeguarding lead for the CCG was very responsive and supportive to concerns raised. Information about learning from concerns was shared with the relevant staff at the practice.

Good

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records EMIS Web. Staff were alerted with 'pop ups' or flags when patient's records were accessed. Care plans were in place for both children and adults at risk. Patients who were seen as having a potential of concern or 'in need' were monitored and discussed regularly.

The practice had a chaperone policy, which was visible on the waiting room and in consulting rooms. Formal training for chaperone support had not been provided to staff. The usual practice was if required practice nurses were requested to support patient as and when required. Not all of the six patients we spoke with told us they were aware of the availability of chaperones if they required it.

Medicines management

We looked at the systems for medicines used at the practice and the safe keeping of blank prescriptions. We reviewed the dispensing service provided at the practice.

Staff told us about the practices for safe medicines administration and storage at the practice. Medicines stored in the dispensary, treatment room and medicine refrigerator were stored securely. There was a policy for ensuring that medicines requiring cold storage, such as vaccines, were kept at the required temperatures. The policy described the action to take in the event of a potential failure. The practice staff followed the policy. There was no monitoring of the dispensary room temperature where medicines were stored to ensure they were kept within the manufacturers recommended temperature ranges.

Processes were in place to check medicines were within their expiry date and suitable for use. All medicines we checked were within their expiry date. Stock medicines were checked monthly. Expired and unwanted medicines were disposed of in line with waste regulations. Records were kept of medicines used at the practice including ordering, stock levels and disposal or use. Appropriate systems were in place for controlled medicines, such as storage and record keeping, kept in the practice. There were safe systems in place for the security of keys to where medicines were stored with only named people having access. Doctor's bags were checked every two months for expiry dates of medicines and secured safely when not in use.

The practice had a GP who was the medicines management lead. A member of staff took the lead on ensuring drug recall and safety alerts were disseminated to GPs, nursing and dispensing staff. There were Standard Operating Procedures in operation for the handling of medicines in the practice dispensary.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Nursing staff had access to up to date guidance and patient group directions and nurses had received appropriate training to administer vaccines.

There were systems in place for monitoring patients with polypharmacy (multiple medications prescribed). 95% of these patients (January 2014) had received an annual review to check safe medicines had been prescribed. We heard how information about the medicines prescribing at the practice was reviewed and discussed in team meetings and clinical audits. For example the use of blood thinning medicines in the treatment for heart and vascular disease.

Repeat prescriptions were reviewed and signed by a GP before they were given to the patient or and in most cases before medicines dispensed, the exception was urgent prescriptions for a patient's acute needs where agreed protocols were put in place. Blank prescription forms were stored safely centrally. Methods of monitoring blank FP10 prescriptions for printers were not in accordance with national guidance as there was no process for logging which printers they were assigned to. Prescription pads/ forms used for home visits were logged in and out of the practice and kept securely.

Patients said the prescription service was quick and managed well. Also staff were friendly and helpful. Patients could either drop a prescription request off at the practice, fax, post, or use the dedicated EMIS Web prescription on line request service. Patients could phone the practice for a repeat prescription in exceptional circumstances.

We met and spoke with a member of staff working in the dispensary at the practice. We were told the practice dispensed approximately 3600 medicines per month. Part of their service was to provide medicines in monitored dosage systems, although no one was currently receiving this service; they also had engaged an external contractor to provide an additional service of home delivery for those housebound patients. The service provided deliveries twice a week, Tuesdays and Thursdays. Medicines were bagged

and there were methods of logging the deliveries and receipt of medicines. Confidentiality may have been compromised by the patients repeat prescription pinned to the outside of the bag when handled by other personnel such as the delivery driver.

Dispensing staff at the practice described and showed us how they managed patient's prescriptions. Staff were aware that prescriptions should be signed by the GP before being dispensed. We were shown the checks and the systems of monitoring for patients prescriptions and the dispensing at the practice and found these to be satisfactory. When splitting manufacturers packs of medicines, expiry dates and batch numbers were recorded and patient information leaflets were supplied with the medicines.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly. Dispensing staff told us they felt they were supported well to carry out their roles and had access to training and on line resources. Support was routinely provided from the pharmacist from the Gloucester CCG.

Cleanliness and infection control

We observed the premises to be clean and tidy. The practice employed directly their own cleaner and had developed cleaning schedules for all but the treatment room which was the practice nurses' responsibility. They did not use in place a recognised approved systems for equipment. For example colour coded mops and cloths. They also used locally sourced branded cleaning solutions. We were informed visual cleaning audits were carried out by the practice manager although these were not recorded.

Patients we spoke with and who wrote in the comment cards said they had found the practice clean, tidy and comfortable. Patients had commented they had found the practice environment hygienic and had no concerns about infection control.

We were told there was a nurse lead for infection control at the practice. We saw that there was an infection control policy that set out staff's responsibilities. Staff were able to access this electronically and in hard copy in the practice.

We spoke with the practice nurse on duty about infection control audits. We were told that there was a daily schedule of infection control checks carried out by nursing staff in the treatment room before and after each surgery session. This included hand wash facilities, work surfaces and clinical waste. However, these checks were not recorded. They were able to show us documentary evidence of infection control audits of the whole premises carried periodically at the practice. An in depth audit was carried out by an external specialist in 2012 where all areas of risk were identified and actions put in place. The last infection control audit in January 2015 showed no significant issues identified. Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment and consulting rooms.

There were systems in place for managing clinical waste; appropriate waste bins were available in consulting rooms and treatment areas. An external contractor was engaged to remove and dispose of clinical waste at the practice. There was a system and instructions given to staff for the receiving and handling of specimens brought to the practice and sent from the practice to the local laboratory.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).The practice manager provided evidence an external contractor was engaged to carry out this check in the next few weeks.

Safe systems and guidance was available for staff in regard to chemicals and cleaning fluids that should be kept in accordance to the Control of Substances Hazardous to Health Regulations 2002. Items were stored safely away from patient areas.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All of the portable electrical equipment was in a schedule of being tested, due to be completed in January 2015.

Good

Are services safe?

Staffing and recruitment

We looked at documents relating to the recruitment and employment of all six staff employed at the practice since October 2013. The records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, and qualifications. Registration checks were carried out with the appropriate professional body and criminal records checks through the Disclosure and Barring Service.

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that new staff were provided with information such as a job description and details about the practice. Records of the interview and selection process were kept. There was a formal induction process with a checklist to ensure that staff had been provided with the necessary information about their role and the service. New staff were provided with a three month probationary period.

There were arrangements for planning and ensuring the number of staff and mix of staff needed to meet patients' needs was met. There were designated roles for staff. Some administration staff had multiple roles to support the staff team and replaced or supported reception staff when required when the practice was busy. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. We observed on the day of the inspection there were sufficient staff on duty in the practice. We also saw how flexible and responsive staff were when a GP was unable to attend the other practice in the partnership in Lydbook because of the snow and ice. One GP changed their plans for the day to ensure that patient's needs were met.

Patients told us they were always able to obtain an appointment, were seen in good time and didn't feel rushed in their appointments. Staff were friendly and approachable.

Monitoring safety and responding to risk

We looked at the systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building and the environment. For example fire, water and the chemicals used at the practice. Each risk was assessed and actions recorded to reduce and manage the risk, such as the fire safety. The practice manager had instigated an overall comprehensive health and safety risk assessment by an external provider in 2014. This was because they had identified gaps in the schedules of expected maintenance and safety checks that should have been carried out. Action plans were produced and we saw evidence these were being completed including asbestos assessment and boiler servicing. The practice also had a health and safety policy which was included in the staff handbook. Health and safety information was displayed for staff to see. Health and safety training was incorporated in new staffs induction training.

We saw that any risks were discussed within team meetings. This included the welfare, clinical risks and the risks to patient's wellbeing which were discussed as they occurred by the GPs and nursing staff. There were systems for monitoring patients with long term conditions, end of life care and patients and families who were identified as at risk in regard to safeguarding and abuse.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support. There was a training programme for this to be repeated annually for all staff. Emergency equipment was available including access to oxygen and an automated external defibrillator.

When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Emergency medicines were stored safely. These included those for the treatment of cardiac arrest, anaphylaxis and low blood sugar. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. There was also a system to check that equipment such as defibrillator electrode pads did not expire and were renewed regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Such as power failure, adverse weather, and

Good

Are services safe?

unplanned sickness. Staff were also provided with guidance and telephone numbers to contact relevant organisations to ensure continuity of the service. The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. Partners, the salaried GP, locums and nursing staff had access to the on line resources of information available. There were practice meetings where the implications of changes to best practice and the practice's performance discussed and actions agreed.

The practice staff assessed and identified high risk patients, such as those with long term conditions, mental health needs, and patient requiring palliative care. The practice staff participated in partnership working with other health and social care professionals and services such as to avoid patients unplanned hospital admissions. Care plans were in place for people who had long term care or complex health needs.

The GPs told us they all participated in caring for patients with long term conditions such as chronic heart disease, kidney disease and dementia. The practice nurses supported the GPs with this work for patients with on-going long term conditions. The lead practice nurses had undertaken further training by completing a diploma in coronary heart disease.

The intelligent monitoring information was made available from the practice and NHS Quality and Outcomes Framework (QOF) information. QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures for maintaining patient health. The information from the year end of March 2014 showed the practice was in line or above with expected national levels of achievement. For example, patients who were diagnosed with diabetes had screening for cholesterol levels, monitoring of their blood pressures and had an annual foot examination during the previous 12 months.

The practice gave information that they had 29 patients who were registered as having a learning difficulty all of whom had an annual health check this year. There were a small number of patients identified with enduring mental health needs. There was a programme of medication reviews and annual health checks (96% achieved) in place for these patients.

The practice had made steps to increase dementia diagnosis and there had been an increase in 11 patients since April 2014 who had been provided with access to treatment available and had a care plan in place. Of those patients identified and who had an advance care plan in place, 87% had a review during 2014. Advance Care planning is key means of improving care for people nearing the end of life and of enabling better planning and provision of care, to help them live and die in the place and the manner of their choosing.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and other staff showed that the culture in the practice was in which patients were cared for and treated based on individual need. The practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included child and adult protection. Patients over 75 years of age (544) had a named GP and were offered a health check. Of these patients over 75 years of age 77% have had an invite for a health check and 57% have seen their GP since October 2014.

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. Information was provided from QOF, significant events, new guidance and feedback from patients generated clinical audits. For example, an audit was carried out in regard to the use of compression hosiery for patients with heart or vascular problems. This was carried out because patients were returning ill-fitting hosiery. The staff had identified there was no formal review process of checking of appropriate assessment and patient compliance of the use of compression hosiery and had set up a procedure with a 99% success rate and had received positive feedback from patients. There were other audits in place such as in regard to the prescribing and monitoring of treatment and medicines for thinning patient's blood (heart and vascular

Good

Are services effective?

(for example, treatment is effective)

disease). The outcome from these audits identified that improved recording electronically patient's blood test results and using a recognised software programme and treatment was provided safely.

The practice had carried out other clinical audits that had been undertaken in the last year. For example leg ulcer treatment and three audits in regard to medicines prescribing, requests and repeat prescription ordering.

The practice also used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients such as seasonal influenza vaccinations and cervical smear tests. The practice participated in other screening not included in QOF, such as chlamydia testing.

The practice 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.

Effective staffing

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

The team of GPs at the practice had changed during the last 18 months. The most recent changes had included the GP partnership and the salaried GP posts. Evidence of training through the practice was minimal as much of the information was held individually by staff and the provider was in the process of collating this information. However, two joint learning/away days with other members of staff had taken place. GPs had obtained the specific training they required such as updates with safeguarding children training.

The lead nurse and practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. The lead nurse had completed a Diploma in Coronary Heart Disease. The practice nurses maintained their knowledge for areas of care such as immunisations. A member of staff had been trained as a phlebotomist (blood testing) another in spirometry (tests to check for lung disease) and a health care assistant was provided with extra training to provide influenza vaccinations. A new nurse had been recruited and was intended to start in March 2015.

We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. We saw information and staff told us that there was a system of annual appraisals which identified individual learning needs from this action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the district nursing team. The practice hosted other health care provider's services such as once a week the local community psychiatric nurse.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. Regular meetings with other professionals such as district nursing teams, health visitors, palliative care team and social workers took place. This system worked well and there was a team approach to supporting their patients.

We heard how the practice worked with other health care providers in the area such as a local nursing and care home. The practice GPs regularly visited patients living in the care homes at least once a week. The staff had found they had a good working relationship with the GPs and other staff at the practice. Patients had expressed they liked the GPs who attended them.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

Good

Are services effective?

(for example, treatment is effective)

record called EMIS to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The practice also had an internal system to shared documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Staff had access to key policies and procedures in regard to mental capacity, assessment and obtaining consent. This included best interests' decision making processes for those people who lack capacity. There was a practice policy for documenting consent for specific interventions including a patient's verbal consent which was recorded in the electronic patient notes.

Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Patients told us that consent was asked for routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patient's declined this was listened to and respected.

Health promotion and prevention

The practice offered a health check with the health care assistant or practice nurse to all new patients registering with the practice. Through this process patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the asthma or heart conditions clinics or reviews. The practice provided information and support to patients to help maintain or improve their mental, physical health and wellbeing. For example, by enabling access to a stop smoking group and by offering smoking cessation advice to patients who smoked. The practice offered NHS Health Checks to all its patients aged 40 to 75 years, a weight management service and provided a sexual health service for young people known as 4YP service. The practice supported public health promotion events, such as influenza vaccination or stop smoking events.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was either above average or slightly below for the CCG. The practice staff were flexible with providing immunisations and were able to offer immunisations at the convenience of the patients/ patient's families and not just at set clinic times.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice or support. The practice has agreed to be involved in social prescribing such as the provision of self-help advice and a provide patients with access to community networks. For patients requiring assistance with weight management GPs and practice nurses referred them to commercial weight loss organisations and fitness programmes.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from a survey by the practice's patient participation group (PPG) for March 2014 and patient's comments to Healthwatch. Patients gave positive comments about the staff and the level of care received.

There were 25 patients who completed CQC comment cards to tell us what they thought about the practice. We also spoke with six patients on the day of our inspection. Patients said they had very positive experiences of care and support from the practice and the staff. Patients said staff were treaty with dignity and respect and empathy. Patients had found the staff helpful and caring.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment 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.

We saw that staff followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Telephone calls to the rear of the reception administration area which was a reasonable distance between the waiting room area and reception desk which helped keep patient information private.

Care planning and involvement in decisions about care and treatment

Patients we spoke with on the day of our inspection 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 they wished to receive. This was reflected in the 25 comment cards where patients said they felt they were listened to and taken seriously with appropriate care and advice being offered. Patient also told us when they decided to decline treatment or a care plan this was listened to and acted upon.

Translation services were available for patients who did not have English as a first language. We saw notices in the reception areas, leaflets and on the practice website informing patents this service was available. Staff told us they rarely had to use this service for the patients they supported. An induction hearing loop was in the surgery reception/ treatment areas should it be required for hearing aid users.

A care service, for older people whose patients were supported by the GP practice gave examples of how the GPs involved relatives, with the patient's permission, in care decisions. This included contacting them by phone or by meeting them at the care home.

Patient/carer support to cope emotionally with care and treatment

Patients gave positive comments about the emotional support provided by the practice staff. For example, we were told by one patient how they were supported in caring for their partner with long term health conditions and when their partner was terminally ill. They had found they were able to speak to the GPs and nursing staff who answered their questions well.

There were notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations external to the practice. The practice's electronic patient record system alerted GPs and other staff if a patient was also a carer. The practice manager told us they were implementing a carer's register so that all staff were aware of those patients who were also carers. The practice provided carers information packs and obtained support from carer's advice services to direct carers to additional help. We spoke to a member of a carers group who was also a PPG member who told us about the pilot carer's volunteer link visitor scheme that the practice had just signed up for to ensure patients had support from within the community.

We heard from a care service whose patients were supported by the practice about the GPs and other staffs caring attitude. We were told about how a GP had contacted the service in regard to a sudden death of a member of staff who worked at the care home. They had found the GP was very supportive to staff and the patients through a difficult time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and the needs of the practice population were understood and systems were in place to address their identified needs. For example, through the practice patient survey in 2013 changes were made to ensure patients could see their GP of choice and continuity of care was provided. The practice had provided an additional surgery session and had commenced recruiting new partners to provide continuity of care to patients.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. There was also a GP triage service so that urgent requests were assessed and prioritised according to need. The practice had also identified that it wanted to improve the care of people with long term conditions and in addition to their care plan they were able to offer to 2% of the practice population a direct telephone line of with their GP or the practice nurse.

There was a computerised system for obtaining repeat prescriptions and patients used both the email request service, posted or placed their request either in a drop box in reception or outside the building. Patients told us these systems worked well for them.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice, including the implementation of on line patient access to order repeat prescriptions and book or cancel appointments.

Tackling inequity and promoting equality

The practice had recognised they needed to support people of different groups in the planning and delivery of its services. The practice was aware of the need to support its patients who were carers and staff were in the process of developing a carers list and support system.

Patient areas were all on ground floor level and were accessible and suitable for wheel chair users and people with limited mobility. On the first floor there was a small area for storage, administration and meetings. The patient waiting area was large enough to accommodate patients with wheelchairs and prams and allowed generally for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

The practice reception was open from 8.30am-6.pm five days per week. Each day emergency appointments were available between 8am-8.30am, 1pm-2pm and 6pm-6.30pm. Routine appointments were available from 8am-1pm and 2pm-6pm. The practice referred patients to NHS 111 for an out of hour's service to deal with any urgent patient needs when the practice was closed.

Information was available to patients about the opening times and appointments on the practice website, these were also available on display in the practice waiting areas and provided to patients when they registered with the practice. This information included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave patients the telephone number they should ring for the out of hours service

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to either speak to a GP or attend appointments on the same day of contacting the practice.

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, the practice manager, who handled all complaints in the practice.

Information was available to help patients understand the complaints system. It was included in the practice information leaflet, on display in the patient areas and the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice website. The information contained details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. The patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the information about the 15 complaints the practice had received in the 12 months from December 2013 to December 2014. The complaints ranged from a variety of issues, some were in regard to attitude of staff, diagnosis delays or referrals to other healthcare providers.

We saw that from the records we reviewed the complainant had been kept informed about the complaint investigation and the outcome. The practice had looked at how it could improve and avoid incidents reoccurring and patients raising similar complaints in the future. There was evidence that staff had put changes in place including training, changes in administration practices and care planning for patients. Patients had the opportunity to make comments; a comments box had been recently made available in the practice reception. Equally compliments were reviewed by the practice and patients were responded to and thanked for their feedback.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care in a confidential safe environment and promote good outcomes for patients. They also wished to show patients courtesy and respect at all times

When we spoke with three of the GPs, a practice nurse and members of administration and the dispensary staff. They all understood what the vision and values of the practice and the aim of the practice team to achieve good outcomes for patients and the community. All of the staff we spoke with were aware of the significant changes in the practice management and leadership and the drive to improve the delivery of the service and they expressed they valued their involvement in taking the service forward.

Governance arrangements

The practice had a number of policies and procedures in place to govern how services were provided. These policies and procedures were available electronically, some in hard copy for easy access. There was a system to ensure that policies and procedures were reviewed and updated where required on an annual basis. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, medicines management and vaccines.

There was a leadership structure with named members of staff in lead roles. We were told when a new partner joined the practice these roles would be reviewed. For example, the new lead nurse role supported the nursing care provided at the practice. A GP partner was the lead for safeguarding. All of the members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, the effective use of compression hosiery for patients with heart or vascular problems. This was carried because patients were returning ill-fitting hosiery. The practice had carried out a cycle of audits in regard to the prescribing and monitoring of treatment and medicines for thinning patient's blood (heart and vascular disease). The outcome from these audits identified that improved recording electronically patient's blood test results and using a recognised software programme and treatment was provided safely.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the Health and Safety audit carried out in 2014, which addressed a wide range of potential issues, such as the environment. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The practice partners met weekly for governance, business and to discuss patient's needs where plans were put in place to develop the service or specific care for individual patients.

Leadership, openness and transparency

Practice staff met every two months to discuss the service delivery within their own peer groups. Important information was disseminated between these meetings should urgent issues arise.

We heard from staff at all levels that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice employed a practice manager who oversaw the administration management over the partnerships two locations. Their role included being responsible for human resource policies and procedures and their implementation. We reviewed a number of policies, such as those for employing and supporting new staff and found they were up to date and had the required information. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the annual patient surveys and saw that patients had highlighted a range of issues that they thought could be improved. This included providing better

Are services well-led?

Good

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

access to booking appointments and seeing their GP of choice. The practice implemented changes in regard to these concerns by adding another surgery session per week which gave better flexibility to obtaining treatment from patients' GPs of their choice. The on line booking system for repeat prescriptions and appointments had commenced in December/ January 2015 had been received well by patients we spoke to.

The practice had a virtual patient participation group (PPG) that had supported the practice to carry out annual surveys. We met and spoke with a representative of the PPG who told us about their involvement with the practice and the plans they had for developing the relationship and support to the practice patients. They provided information of how the practice had listened and responded to the questions they raised and the feedback they had provided.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. This enabled staff to raise concerns without fear of reprisal.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff confirmed that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were provided with opportunities to develop new skills and extend their roles.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.