Blakeney Surgery

Quality Report

Mill End
Blakeney
Gloucestershire
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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?	Requires improvement
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 Blakeney Surgery on 26 January 2015. Overall the practice is rated as good.

Specifically we found it good for effective, caring, responsive and well led 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. It required improvement for providing safe services.

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. Staff were trained and knew how to recognise signs of abuse in older people, vulnerable adults and children. Staff were aware of their responsibilities to share information and properly record documentation of safeguarding concerns.
- 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.
- The practice provided a focussed service for patients with learning difficulties.
- Patients told us they were treated with compassion, dignity and respect and that they felt involved in their care and decisions about their treatment.

Summary of findings

- Information about the services provided and how to complain was available and easy to understand. Complaints were managed well.
- 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.

We saw areas of outstanding practice:

- The practice provided for some patients' sigmoidoscopy (bowel examination with the use of a camera) clinics, reducing the need for patients to travel long distances to hospital.

The provider must:

- The medicines kept at the practice should be managed and kept securely. Medicines in the treatment room, the store room, the dispensary and the cupboard where filled monitored dosage boxes were stored awaiting collection must be reviewed and improved.

In addition the provider should:

- Improve recording details about significant events.
- The provider should put a planned recorded programme of carrying out risk assessments for the building in place.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to 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' health and support were assessed and well managed. There were enough staff to keep patients safe.

However we found some areas which could be improved, for example, some of the systems for the security of storing medicines kept at the practice and the dispensary should be reviewed.

Are services effective?

Good

The practice is rated as good for providing effective services. Information from NHS England and the practice showed that patient outcomes were at or above average for the locality. Staff referred to guidance from 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. The practice provided information and support to patients for promoting good health. 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 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 compassion, 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.

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. The staff and the practice had a very flexible approach to providing support to patients and to the local community surrounding the practice. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly 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. There was a focus on the development of individuals and involvement in research projects. 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. Information received from NHS England showed us that just above 13% were over 65 years old. Around 6.4% of the practice patients were 75-84 years old and just over 1.3% 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 over the age of 75 was provided with a named GP. There was multidisciplinary team working to support patients to remain in their own homes.

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 52% of the patients had long standing health conditions, which was similar to the national average. Nursing staff had lead roles in chronic disease management. Patients who had been deemed at risk were provided with support from multidisciplinary team. Care plans were in place to prevent hospital admissions. Longer appointments and home visits were available when needed. These patients had 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. Just below 14% of patients were less than 14 years of age. There were systems in place to identify and follow up children who were at risk. Appointments were available outside of school hours and the premises were suitable for children and babies.

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). Over 31% of patients registered with the practice were working aged from 15 to 44 years, 32.4% were aged from 45 to 64 years old. Less than 1% of the working population were unemployed which is below the national average of 6.3%. The needs of the working age population, those who could not attend the practice during working hours were met by offering access through extended hours three days per week. The

Summary of findings

practice offered online 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.

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 patients access to and gave information about various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and knew how to contact relevant agencies. The percentage of patients who had caring responsibilities was 18.9% which is similar the national average of 18.5%. The practice had systems in place 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 a care plan in place. Patients had access to mental health support which visited the practice on a regular basis.

Summary of findings

What people who use the service say

We spoke with four patients during the day. We received information from the 15 comment cards left by patients at the practice premises.

Patients said there were enough staff to maintain the smooth running of the practice and there was always enough staff on duty to keep patients safe. Feedback from patients we spoke with confirmed that communication was good between the practice and other staff associated with the practice.

When we spoke with patients they told us that consent was asked 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 they declined this was listened to and respected. Patients confirmed their GP involved them in care decisions and they to us that they also felt the GP and other staff were good at explaining treatment and results. Patients 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.

Information showed that patients were satisfied with how they were treated. Patients said they felt the practice offered a more than excellent service and also told us that staff were understanding, helpful and caring. They also said that staff had treated them with dignity and respect. Patients were always seen on the day of their request, this included patients requiring home visits.

Representatives from the Patient Participation Group said the practice listened to them about the comments patients made about the service. 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.

Areas for improvement

Action the service MUST take to improve

- The medicines kept at the practice should be managed and kept securely. Medicines in the treatment room, the store room, the dispensary and the cupboard where filled monitored dosage boxes were stored awaiting collection must be reviewed and improved.

Action the service SHOULD take to improve

- Improve recording details about significant events.
- The provider should put a planned recorded programme of carrying out risk assessments for the building in place.

Outstanding practice

- The practice provided for some patients' sigmoidoscopy (bowel examination with the use of a camera) clinics, reducing the need for patients to travel long distances to hospital.

Blakeney 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 CQC Pharmacy inspector and two specialist advisors: a GP and Practice Manager.

Background to Blakeney Surgery

Blakeney Surgery is situated in a residential area of Blakeney, Gloucestershire. The practice had approximately 3,300 registered patients from Blakeney and the surrounding rural areas. The practice is a dispensing practice. The practice provides care and support to a higher number of patients, 5% of the patient population, with a learning difficulty residing in care homes or sheltered accommodation in the area. The practice provides medical cover for 50 community hospital beds in the area.

The practice is located in purpose built premises. There is a central patient waiting and reception on the ground floor with consulting and treatment rooms accessible from this area. The practice is on a general medical service contract with Gloucestershire Clinical Commissioning Group.

Blakeney Surgery is only provided from one location:

Mill End

Blakeney

Gloucestershire

GL15 4ED

The practice supported patients from all of the population groups such as 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 aged from 15 to 44 years, 32.4% were aged from 45 to 64 years old. Just above 13% were over 65 years old. Around 6.4% of the practice patients were 75-84 years old and just over 1.3% of patients were over 85 years old. Just below 14% of patients were less than 14 years of age. Information from NHS England showed that 52% of the patients had long standing health conditions, which was similar to the national average. The percentage of patients who had caring responsibilities was 18.9% which is similar the national average of 18.5%. Less than 1% of the working population were unemployed which is below the national average of 6.3%.

The practice consisted of three GP partners. Of these three GPs there were two male and one female GPs. There were four practice nurses and two health care assistants all of whom provided health screening and treatment five days a week. There were additional clinics implemented when required to meet patient's needs such as the undertaking of influenza vaccinations. There were five members of staff who were employed as part of the pharmacy dispensing team. The practice was open from 8am to 1pm every weekday morning. The practice re-opened from 2pm to 7pm, Monday and Tuesday. From 2pm to 6:30pm Wednesday and Friday. On Thursday it was open from 2pm to 5.30pm. The practice was not open at weekends. The practice referred patients to another provider NHS 111 for an out of hour's service to deal with any urgent patient needs 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 (Regulated Activities) Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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 Gloucestershire Clinical 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.

During our visit we spoke with two of the GPs, a practice nurse, and the dispensing staff on duty. We also spoke with the practice manager and the reception and administration staff. We spoke with four patients in person during the day. We received information from the 15 comment cards left at the practice. We spoke with a member of the district nursing team visiting the practice. We spoke with members of the patient participation group.

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 two GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 14 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included external events that impacted on how support to a patients such as incorrect information given on discharge from hospital. Others ranged from medication prescribing errors and gaps in administration processes.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken to learn from these events. Steps taken included alerting hospital staff about clerical errors in regard to details about patients' treatment and care.

We saw evidence that national patient safety alerts as well as comments and complaints 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 discussed and responded to. However, the records we reviewed did not show the detail of the discussion and the content of the analysis by the GPs or other staff involved. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role. Administration and reception staff were supported to raise any significant events if they occurred.

We saw from summaries of the analysis of these events and a review of complaints which had been received that the practice had put some actions in place in order to minimise or prevent reoccurrence of events. For example, revisiting practices for dispensing repeat medicines and improving how patient information was handled at the practice.

Safety alerts, such as the Medicines and Healthcare Products Regulatory Agency (MHRA), and information was available on the electronic records for staff to readily access. The practice manager leads on escalating concerns to the SEA processes.

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. We were told that all staff at the practice had been provided with level one training for both safeguarding vulnerable adults and children. One GP took the lead with safeguarding at the practice. All of the GPs had been trained to level three, safeguarding children.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware who the safeguarding lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

GPs were appropriately using the required codes on their electronic case management system. This ensured risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead GP for safeguarding was aware of vulnerable children and adults and of the records identifying these patients. Information from the GPs demonstrated good liaison with partner agencies such as social services. They participated in multi-agency working for patients who were at high risk of admission to hospital or A&E by maintaining a register and creating a care plan appropriate for the individual. Through discussion with staff it was clear that patients at risk were discussed and information shared appropriately with other staff at the practice.

Good

Are services safe?

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. Patients told us they were aware of the availability of chaperones if they required it.

Medicines management

We looked at the systems for medication used at the practice. We also looked the dispensing pharmacy service the practice provided. The practice dispensed medicines directly to 71% of their patients.

Staff told us about the practices for safe medication administration and storage at the practice. We checked medicines stored in the treatment rooms and medicine refrigerators. We found emergency medicines and vaccines were stored securely. The medicines kept in the treatment room were not held in a locked cupboard. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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. Expired and unwanted medicines were disposed of in line with waste regulations. Controlled medications were managed by staff working in the dispensary. A practice nurse took responsibility of checks for the doctors' bags. There was a safe system in place for storage, administration and dispensing controlled medicines at the practice. We noted the dispensary was not locked when unoccupied and the cupboard where filled monitored dosage boxes were stored awaiting collection was not kept locked. The entry to the dispensary and the cupboard with the monitored dosage boxes was in an area not accessible to the general public or patients' which was secured by electronic lock.

The practice had a GP who was the medicines management lead but who was not available to speak to on the day of the inspection. Dispensing, nursing and administration staff were able to describe some aspects of the processes in place for reviewing prescribing at the practice. We heard how information about the medicines prescribing at the practice was reviewed and discussed in team meetings and included in clinical audits. For example looking at calcium and vitamin D therapy for patients at risk of osteoporosis.

The nurses and health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that these staff had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were not handled fully in accordance with national guidance; these were logged when received into the practice but there was no system to track them through the practice for audit purposes.

We met and spoke with staff working in the dispensary at the practice. We were told the practice provided medicines to 2,350 patients. Part of their service was to provide medicines in monitored dosage systems; they did not provide a service of home delivery for those housebound patients. However, they told us they did their upmost to accommodate patients in these circumstances by using the dial-a-ride service to deliver medicines although there was no formal arrangement for this.

Dispensary 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.

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. New staff were commenced on training when appointed and were supported by experienced staff.

Cleanliness and infection control

We observed the practice premises to be clean and tidy. Patients we spoke with and who provided feedback to us in the comment cards said they had found the practice clean, hygienic and had no concerns about infection control. We

saw there were cleaning schedules in place for daily, weekly and monthly tasks. Cleaning spot checks were carried out by the Practice Manager but these checks were not recorded.

We saw the practice had details in regard to the products authorised for use for cleaning at the practice and these products were stored safely in a dedicated locked cupboard. Control of Substances Hazardous to Health information was included in the cleaning policy.

The practice had a lead person responsible for infection control. This person told us they received specific training for infection control 18 months previously and cascaded their learning to other staff at the practice. All staff had received induction training about infection control which was specific to their role. The lead person told us the most recent infection control audit had been completed for 2014. They did describe the daily, weekly and monthly checks they had in place for example the cleanliness of the fridges, work surfaces and sink areas of the treatment areas.

An infection control policy and supporting procedures were available for staff to refer to. For example, the requirements for personal protective equipment including disposable gloves, aprons and coverings and we saw these were available for staff use.

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 rooms.

Staff were able to describe and show us the systems for safe disposal of clinical waste. The practice had a contract with a clinical waste company.

Equipment

Staff 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. We saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, and blood pressure measuring devices.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). There was a risk assessment process to determine which staff role should be DBS checked.

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 about their job role and the key policies of the practice. Each member of staff was provided with a key policies and procedures which informed them of their employment responsibilities. Copies of their contractual agreement were also kept.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place. 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. This was reflected in information received from patients.

Monitoring safety and responding to risk

The practice had some systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. Some of these were informal and not recorded; there was no planned programme of carrying out risk assessments for the building and the practice manager did not maintain a risk log of the current concerns. There were systems in place for fire safety, disposal of clinical waste and regular servicing of the gas boiler was carried out. Health and safety information was displayed for staff to see.

We saw that any risks were discussed within team meetings. Welfare, clinical risks and the risks to patient's wellbeing were discussed daily and weekly by the GPs and nursing staff. There were systems for monitoring patients with long term conditions, end of life care and patients being treated for cancer.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

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

All members of staff, they all knew the location of this equipment and records confirmed that these were usually checked regularly. Emergency medicines were stored safely. Medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. There was no list of content of the emergency medicines box. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions had been recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the power company and telephone service provider. They also had details of the contingency plans for relocation of the practice and services should access to the building be prevented, This policy had been updated in October 2014 and it reflected working with the local Clinical Commissioning Group to ensure continuity of medical services to the area.

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. One of the GPs at the practice sat on the Gloucester Clinical Commissioning Group board and had a role with the Forest of Dean Practice Based Commissioning Executive Group. This enabled them to keep updated with current guidance and share learning and disseminate information to colleagues at the practice. This was through practice meetings where the implications for the practice's performance and patients were discussed and actions agreed.

The practice used an assessment tool to help identify high risk patients and it participated in joint working with other health and social care professionals and services 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 had interests in specialist clinical areas such as caring for patients in the community hospitals, mental health and learning disabilities. Another GP had an interest in nutritional health. The practice nurses supported the GPs with caring and providing support for patients with on-going long term conditions. One practice nurse prescriber led on triaging urgent appointments, where they reviewed patients' needs and either escalated to the GP on duty or in the case of minor ailments treated accordingly.

The GPs had been involved in different aspects of clinical research. This included a learning difficulties study, children and diabetes. Information from the research and audits was managed well and shared. GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. We heard about discussions the GPs and nursing staff had regarding improving outcomes for patients. The records for Significant Events Analysis (SEA) confirmed that this happened.

The intelligent monitoring information we had available and that provided by the practice showed the practice was in line or above with expected national levels of achievement for the year 2013 to 2014. For example, 98.4% of diabetics registered at the practice had an annual foot examination. Of their patients diagnosed with a mental health issue, 91.4% had received a physical health check.

The information supplied by the practice showed that they had a programme for ensuring all of the 146 patients (5% of the practice patients) who were registered as having a learning difficulty had an annual health check. There was also a programme of medicine reviews specifically for patients on multiple medicines (polypharmacy) where 100% of the patients had been reviewed.

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, and a responsibility (a named GP) for patients over 75 years of age. One GP took the lead on developing services for patients with mental health needs and learning difficulties.

We spoke with GPs and the practice nurses about how they reviewed and assessed they were meeting patient's needs. We looked at information about the practices achievements for the Quality and Outcomes Framework (QOF). 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 2013/2014 Blakeney Surgery achieved 99.3% out of 100% Quality Outcomes Framework (QOF) points.

We were told that the responsibility for planning and delivering care to patients with long term health conditions was with the practice nurse team. There was a system of call and recall managed by the practice nurse team with a dedicated administrator coordinate communication with patients. Individual nurses who took the lead in particular health needs such as diabetes or asthma.

Good

Are services effective?

(for example, treatment is effective)

The practice showed us examples of clinical audits that had been undertaken. Five had taken place during 2014 and included audits of procedures/investigations (sigmoidoscopy) carried out at the practice in regard to complications and outcomes for patients. Another was in regard to revisiting an audit carried out in 2012 for treatment for patients with osteoporosis or those at risk from osteoporosis. Staff were very positive about the culture in the practice around audit and quality improvement and that there was an expectation that all clinical staff should undertake or become involved in the audits carried out.

The practice had looked at how it provided support to patients for end of life care. There was a palliative care register and GPs provided all end of life care in and out of hours to ensure continuity of care for people. Patient's needs and the support for their families were regularly discussed in the practice as well as in multidisciplinary meetings.

The practice also participated in research we were told in the current programme they were looking at aspects of care for patients with learning needs.

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 annual basic life support for clinical staff. The GPs had different clinical interests/ experience in providing care to patients. One GP led in psychiatry and learning disabilities another led in providing medical care to the patients at the two community hospitals the practice supported. Another had an interest in nutritional health. GPs were able to offer other services at the practice such as sigmoidoscopy (Bowel screening) and minor surgery at the practice reducing the need for patients to travel long distances to hospital. 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).

GPs were provided with protected time for learning with five days study leave each year. There was an on-going plan of in house learning/ presentations with guest speakers. Examples of this were in regard to specific medicines or health conditions. Lead GPs had obtained the specific training they required such as revisiting safeguarding children training at level three.

Nurse practitioners, practice nurse had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and family planning.

We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisals identified 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. Patients had access through a referral by their GP to an NHS mental health nurse who visited once a week at the practice. The practice was involved with social prescribing pilot and was able to offer patients' access to weight loss programmes and other provider led self-help services. Patients could also access private complimentary therapies hosted by the practice on the practice premises, such as podiatry.

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 the community matron, district nursing teams, health visitors, and palliative care team took place. Staff felt this system worked well and there was a team approach to supporting their patients. We obtained positive feedback from a health care professional who came in contact with the service on a regular basis. We were told they were a very friendly and open staff team who never failed to provide support to other professionals.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

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 record called VISION 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, the Children Acts 1989 and 2004 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.

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. The practice identified that they had ensured that all their patients with a learning disability had detailed care plans including capacity of the individual to provide informed consent. They did recognise that similar care and support for patients with dementia needed further development. Care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

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 who 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

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the diabetes, 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 offering smoking cessation advice to patients who smoke. The practice told us they had a Stop Smoking Advisor and had 33 patients involved with their current success rate (2014) high at 89%. The practice offered NHS Health Checks to all its patients aged 40 to 75 years and 71% of its patients in this age group had taken up this service during the last year.

There was a 5.4% turnover of patients registering at the practice. We were told about the high risk groups that were in the community and the services they provided to encourage them obtaining healthcare and support. This included the patients with learning difficulties and to support them they ran a 'stepping stones' clinic to provide healthcare and healthcare advice. They also commenced to provide information about health care in different formats specifically to help patients with learning difficulties. We heard how a practice nurse had visited one of the learning difficulties homes to provide health promotion advice and support. The local toddler group was provided with support from the surgery's designated Nursery Nurse

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.

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 NHS England, feedback from patient surveys' undertaken during 2013 to 2014 by the practice's patient participation group (PPG) in partnership with the practice staff. Information showed that patients were satisfied with how they were treated and this was reflected in the comments we received.

There were 14 patients and a visiting therapist who had completed CQC comment cards to tell us what they thought about the practice. All of them commented positively about the service they experienced. Patients said they felt the practice offered a more than excellent service and staff were understanding, efficient, helpful and caring. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said peoples' dignity and privacy was respected.

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. The practice telephones were set back from the reception desk which was shielded by glass partitions which helped keep patient information private.

Care planning and involvement in decisions about care and treatment

Information from patients we spoke with showed patients experienced being involved in planning and making decisions about their care and treatment and generally felt the practice did well in these areas. When we spoke with two patients with learning difficulties and a carer who supported them they were able to tell us they were always asked and involved in decision making about their care. They found going to see the GPs and the practice nurses a positive experience. Other patients told us the GPs and practice nurses were good at explaining treatment and results. Patients told us if they decided to decline treatment or a care plan this was listened to and acted upon.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The information from patients showed patients were positive about the emotional support provided by the practice staff. For example, one person told us about the caring attitude shown to them in regard to their health problems and told us that they found the staff to be supportive and very helpful.

The practice told us about the developments they were implementing to help patients who were carers. The practice was involved with a 'carers' pilot scheme with the support of a Gloucester carers charity group. They had focussed staff on checking on patients status, if they were a carer or not, and ensured that information was recorded in patients records. They had provided carer information packs, passed details to the charitable local carers group and had set up health screening programme to ensure they had the health care support they needed. Carers needs were raised and discussed at multidisciplinary meetings as needs arose. The practice had a written protocol in place to ensure all staff followed providing care and support in a consistent way.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs and other staff if a patient was also a carer. We were told that access to appointments was flexible to patients who were carers. We were also told that the GPs and services were flexible and home visits to those patients who needed them in order reduce the difficulties some carers had in attending the practice.

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 had systems in place to maintain the level of service provided. The needs of the practice population, mainly elderly, were understood and systems were in place to address identified needs. For example, the location of the majority of the population they served lived in rural settings, a considerable distance from hospitals and acute services. Additional services provided at the practice were to offer in house anticoagulation monitoring (checks of on-going medication treatment for heart or vascular problems) and sigmoidoscopy (bowel examination with the use of a camera) clinics.

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 triage service, the first point of assessment was carried out by a nurse practitioner, so that urgent requests, minor injuries, were assessed and prioritised according to need. The practice nurse leading this role had been trained appropriately and liaised well with GPs.

The staff and the practice had a very flexible approach to providing support to patients and to the community surrounding the practice. They offered a daily telephone consultation service as well as home visiting accessible to all patients. The practice ensured there was a dedicated clinic, 'Stepping Stone's' for patients with learning difficulties with extra time to allow patients carers to discuss with the GPs and practice nurses any issues that concerned them.

The practice was involved in the Forest of Dean District Council led social prescribing pilot scheme and was able to 'prescribe' or direct patients to other support and services, such as weight loss services or social activities.

There was a computerised system for obtaining repeat prescriptions and patients were gradually using the email request service. The email request service allowed patients to ask for repeat prescriptions electronically. Other patients either posted, faxed or placed their request in a drop box in reception. Patients could also request by telephone. Patients told us these systems worked well for them.

The practice had a well established Patient Participation Group (PPG), which they called their Patient Reference Group. Patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG had been involved in the regular patient surveys in conjunction with the practice and there was evidence that information from these was used to develop services provided by the practice. Such as changes to accessing urgent appointments which we were told was working well. Representatives from the PPG said the practice listened to them and also to the comments patients made about the service.

Tackling inequity and promoting equality

The practice had recognised they may need to support people of different groups in the planning and delivery of its services. Such as patients who had learning difficulties who needed extra support and different methods of providing health information to them. They had implemented dedicated clinics, heath promotion leaflets and worked to build relationships with people living in the local community support schemes. The practice had identified that they met the language needs of the majority of the patients' they currently provided a service for. Patients and staff had access to telephone translation services should these be required.

The practice ensured that patient areas were all on ground floor level and were accessible and suitable for wheel chair users and people with limited mobility. We saw that the waiting area was large enough to accommodate patients with wheelchairs and patients with prams and allowed easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice and included baby changing facilities.

Access to the service

The practice was open from 8am to 1pm every weekday morning. The practice re-opened from 2pm to 7pm, Monday and Tuesday. From 2pm to 6:30pm Wednesday and Friday. On Thursday it was open from 2pm to 5.30pm. The practice was not open at weekends. The practice referred patients to another provider NHS 111 for an out of hour's service to deal with any urgent patient needs when the practice was closed.

Comprehensive information was available to patients about appointments on the practice website; these were

Good

Are services responsive to people's needs?

(for example, to feedback?)

also on display in the practice waiting areas and are 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 the telephone number they should ring and provided information on the out-of-hours service.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

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 make 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 who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take away if they wished to with 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. 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 10 complaints the practice had received in the last 12 months and found they were satisfactorily handled and dealt with in a timely way. The complaints ranged from a variety of issues such as clinical care. Some were comments made by patients about other organisations associated with the provision of care, external providers, which were handled as a complaint and referred onto these organisations. We saw that from all complaints the practice had looked at how it could improve. Apologies were given and actions were put in place to avoid events reoccurring and patients raising similar complaints in the future.

There was a method to identify common areas of complaints. Each complaints or comments were also reviewed. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team.

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 which set out in its aims and objectives and its patients charter. Their vision included to provide a high quality care, act with integrity and complete confidentiality and ensure that every person was treated fairly and without discrimination.

When we spoke with the GPs, the practice nurses and the staff on duty they all understood what the vision and values of the practice. We heard how they had valued the caring ethos at the practice and how this was reflected by their colleagues and staff team. This ethos was reflected in the comments we received from patients and professionals who came in contact with the service.

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. We saw that most of these policies and procedures were updated. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for supporting patients who were carers.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. One GP took the lead for clinical governance. All of the members of staff we spoke with were all 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. We saw that Quality Outcomes Framework (QOF) data was regularly discussed at monthly team meetings and plans were put in place to maintain or improve outcomes.

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, reviewing outcomes for patients who underwent examination of their bowel (sigmoidoscopy) and minor surgery carried out at the practice.

The practice manager described the arrangements for identifying, recording and managing risks. The practice manager told us they carried regular 'walk rounds' to check risks in the building and they were able to describe the basic risks they observed for and what actions they took when they identified a concern. However, there was no formal recorded risk assessment process, policy or procedure for the building.

The practice held monthly governance meetings and business meetings where issues were discussed and plans put in place to develop the service.

Leadership, openness and transparency

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 manager to ensure all aspects of managing the service were carried out effectively. This 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, comment cards 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 access times for patients to contact the practice about test results. The practice also listened to patients' comments and experiences in regard to overrunning of clinics for one GP. Patients appreciated the extra time given to them during consultations, so that the practice made

Are services well-led?

Good

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

changes to provide 15 minute instead of 10 minute appointments to ensure patients had the time they needed, and they had extended the clinic times to accommodate this.

The practice had a well established patient participation group (PPG), which they called the 'Patient Reference Group. The PPG had supported the practice when they had carried out surveys and met every six months. We met and spoke with two representatives of the PPG who told us about the work they had done and 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 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. There was a focus on the development of individuals and involvement in research projects.

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.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment · The medicines kept at the practice should be managed and kept securely. Medicines in the treatment room should be kept in a locked cupboard, the dispensary is locked when unoccupied and the cupboard where filled monitored dosage boxes were stored awaiting collection should be kept locked. Regulation 12.1, 2(g).