Brampton Medical 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.

Summary of findings

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Summary of findings

Overall summary

Brampton Medical Practice is a rural dispensing practice which consists of one main surgery in Brampton and two branch surgeries at Corby Hill and Wetheral. The practice is registered with the Care Quality Commission to provide the following regulated activities: treatment of disease, disorder and injury; diagnostics and screening procedures; family planning; maternity and midwifery services and surgical procedures.

We carried out an announced inspection on 6 May 2014. During the inspection we spoke with patients and staff. We also reviewed a completed comment card. Feedback from patients was mainly positive. They told us they were satisfied with the care and treatment they received. Whilst the majority of patients we spoke with expressed no concerns about getting through to the practice on the telephone, 42% said they had experienced difficulties in this area. Also, whilst some patients said they had experienced no difficulty obtaining an appointment, 71% said they had experienced problems, and 21% said they had found it problematic to obtain an appointment in advance.

Patients' care and treatment achieved good outcomes and was seen to be based on the best available evidence. Patients were seen to be treated with compassion, kindness, dignity and respect with services organised wherever possible to meet their needs.

The way the practice was managed promoted an open and fair culture which showed a commitment to providing safe patient care, although we found patients were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage them.

There was a strong and visible leadership team with a clear vision and purpose. Governance structures were, overall, robust and there were systems in place for managing risks. The practice had made arrangements to provide care and treatment that was tailored to patients' individual needs and circumstances. For example, steps had been taken to review unplanned admissions and readmissions into hospital for older people. Patients with long term conditions were provided with access to a regular patient care review which monitored their condition, provided them with on-going treatment and advice, and helped them to better manage their own condition. Arrangements had been made to safeguard children and vulnerable patients from abuse or harm, including the provision of training for practice staff. The main practice was open until 18:30pm each week day and on every Saturday morning, to help provide working age patients with easier access to appointments.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall, arrangements had been made to protect patients' safety and well-being. However, the failure to sign prescriptions prior to dispensing is in contravention of relevant legislation and is an unsafe practice and, medicines were not always stored, transported or disposed of safely. We have set a compliance action under Regulation 13 of the Regulated Activities Regulations (2010) in relation to the concerns we identified.

Are services effective?

Arrangements had been made to make sure services were delivered effectively. Care and treatment was being delivered in line with current published best practice. An effective clinical audit system was in operation. Action had been taken to help ensure the practice was able to provide effective care to its key patient groups, including those with long term conditions and older people. Feedback from patients was mostly positive about the care and treatment they received.

Are services caring?

Patients were treated with kindness, dignity and respect and their privacy was promoted. The majority of patients told us they were satisfied with the care and treatment they received from the practice. Patient responses to the most recent in-practice survey confirmed this. Patients were involved in planning and making decisions about their care and treatment, and where appropriate, they were supported to provide informed consent.

Are services responsive to people's needs?

The provider understood the diverse needs of the population it served and had made arrangements for these to be met. Systems were in place to obtain feedback from patients regarding the quality of the service they received from the practice. This was used to inform planning aimed at improving the care and treatment provided to patients. Improvements were being introduced to enable the practice to be more responsive to patients' needs.

Are services well-led?

There was a strong and visible leadership team with a clear vision and purpose. Governance structures were, overall, robust and there were systems in place for managing risks. However, we found there was a lack of supervision and managerial support for staff working in the dispensaries.

Summary of findings

What people who use the service say

Results from the 2014 in-practice survey showed the majority of patients surveyed (345) were satisfied with the arrangements the practice had made for meeting their needs, and said they would recommend the practice to someone moving into the area. Almost 100% of patients said they would be happy to see the same GP again.

We spoke with 14 patients on the day of our inspection, and most told us they were satisfied with the care and treatment they received. Patients said staff discussed their treatment choices with them and provided clear explanations in a manner they could understand. Patients also told us staff respected their privacy and dignity. Whilst the majority of patients we spoke with expressed no concerns about getting through to the practice on the telephone, 42% said they experienced difficulties in this area. Whilst some patients said they had experienced no difficulty obtaining an appointment, 71% said they had experienced problems. None of the patients we spoke with said they had heard of the practice Patient Participation Group.

Areas for improvement

Action the service MUST take to improve

The practice must ensure that medicines are managed appropriately to protect patients who use the dispensing and immunisation services. In particular, the practice must ensure that prescriptions are signed by the prescriber before dispensing.

Action the service COULD take to improve

The physical effort of opening and closing doors at the practice meant patients with disabilities found them difficult to open and close.

The disabled patients' toilet did not have an emergency buzzer fitted.

Most patients told us getting through to someone on the telephone was difficult, and that it was also difficult to book appointments in advance.

Good practice

Our inspection team highlighted the following areas of good practice:

Patients were reminded of appointments via the mobile text service the practice used.

Brampton Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and a GP. The team included two other CQC inspectors (one of whom was a pharmacist), a GP practice manager and an expert by experience. An expert by experience is somebody who has personal experience of using or caring for someone who uses a health, mental health and/or social care service.

Background to Brampton Medical Practice

Brampton Medical Practice is a busy rural dispensing practice with 15,066 patients. The practice is based in Brampton and covers approximately 400 square miles. The practice serves an area that has a higher level of people with long-standing health conditions, and a higher number of older people aged over 65, years of age, than other practices in the local Clinical Commissioning Group (CCG) area. The practice also has a small group of non-white ethnic patients.

The practice is located in the centre of Brampton and occupies a large building over a number of floors. Brampton Medical Practice provides a range of services and clinics, including, for example, clinics for patients with asthma and epilepsy. The practice is made up of eight GP partners, five salaried GPs, a practice manager and a large team of practice nurses, and management and reception staff. In addition, staff in the dispensary are supported by two dispensers who have been given a temporary supervisory role. One of these staff members is the deputy team leader.The whole dispensing team is also supported by a GP lead who has specific non-clinical time set aside weekly for managerial supervision as well as day-to-day management cover provided by the Practice Manager.

Brampton Medical Practice also operates branch surgeries at the following addresses:

Beech House
Corby Hill

Cumbria

CA4 8PL

Yew Tree Cottage
Wetheral

Cumbria

CA4 8JD

Why we carried out this inspection

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

How we carried out this inspection

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?

Detailed findings

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before visiting, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. We carried out an announced visit on 06 May 2014. During our visit we spoke with a range of staff including: three GPs; the practice manager; the operations manager; three nurses, including the infection control lead for the practice; two pharmacy staff; and some of the staff who worked in the reception team. We also spoke with 14 patients who were visiting the practice on the day of our visit. We reviewed one comment card where a patient had shared their views and experiences of the service with us.

Are services safe?

Summary of findings

Arrangements for reporting incidents were in place, and where concerns had been identified, the practice acted promptly to address them. A culture of openness and a commitment to provide safe patient care was evident at all levels within the practice which encouraged the reporting of errors and 'near misses.' Arrangements had been made to protect patients' safety and well-being. For example, the practice was clean and hygienic throughout. Staff were subject to robust pre and post-employment checks and had received safeguarding training. Patients told us they felt safe using the service. However, we found that patients were not always protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage them. Medicines were not always stored or transported safely. We are therefore setting a compliance action under Regulation 13 of the Regulated Activities Regulations (2010) in relation to the concern we identified.

Our findings

Safe patient care

Arrangements had been made to report, record and learn from safety incidents, concerns or 'near misses'. The patients we spoke with said they felt safe using the services provided at the practice. The practice had a significant event policy which provided staff with guidance on how to report, respond to, review and learn from incidents and significant events. (Significant event reporting is a form of case-based audit which helps staff to critically analyse events which have had, or might have had, a major impact on patients and to learn from such events to prevent reoccurrence.)

The practice participated in the Dispensing Services Quality Scheme. As part of this, practices are required to implement a significant event monitoring procedure to record any serious untoward incidents relating to dispensing. Dispensary staff kept a 'near misses' log book in which details of 30 potential medicine errors had been recorded since the start of 2014. All of these 'near misses' had been found when the final patient check had been carried out by dispensing staff. This showed the checks in place worked well to protect patients.

We were shown a log which provided an overview of the significant events and 'near misses' that had occurred and the actions that had been taken to prevent reoccurrence. The register showed that 15 significant events had occurred during the previous 12 months and these had been dealt with proactively and improvements had been made. For example, when a patient developed an infection following minor surgery we were told a decision was made to carry out an 'infection control audit'. Following this a number of recommendations were made about the improvements that needed to be made. The record indicated that the identified improvements had been carried out.

The practice had clearly defined systems, processes and Standard Operating Procedures (SOP). The purpose of these was to minimise the risk of errors being made and to ensure that national and professional guidance was adhered to. This helped to promote patients' safety.

Learning from incidents

There was continuous learning when things went wrong and we found that robust approaches were used to examine practice. Significant events and 'near misses' were

discussed at Protected Learning Meetings (PLM). We were told information about lessons learnt from significant event reviews was shared with the practice team via email, PLM meeting minutes and completed significant event review forms stored on the practice intranet. A culture of openness operated at all levels in the practice, which encouraged the reporting of errors and 'near misses'.

Safety information from a variety of sources had been used to feed into the significant event review process. This included information from complaints and feedback from clinical audits that had been carried out. All of the staff we spoke with demonstrated an understanding of the importance of carrying out significant event reviews. Safety alerts were handled by the medicines manager who assessed the information and then forwarded it to relevant staff within the practice. Information about safety alerts was available on the practice intranet. A deputy system was in place so that safety alerts would be handled effectively in the absence of the medicines manager.

Safeguarding

The practice had made arrangements to safeguard children and vulnerable adults. Patients told us they felt safe using the services provided. The practice had policies and procedures which covered the safeguarding of both children and vulnerable adults. This meant staff had clear guidance about what they must do to protect vulnerable patients. There were designated staff in the practice that had lead roles for safeguarding children and adults. Staff we spoke with said they knew who the practice safeguarding leads were.

Staff had completed appropriate safeguarding training. For example, all GPs had completed child safeguarding training to level 3. This is the recommended level of training for GPs who may be involved in treating children or young people where there are safeguarding concerns. All staff had also completed adult safeguarding training. Dates for refresher child and adult safeguarding training had been planned for 2014 as part of staffs' protected learning time. This helped to protect patients because staff had received training that was appropriate to their roles and responsibilities, and they knew what action to take to safeguard patients.

The child protection lead GP met regularly with health visitors to consider any current child protection issues, and to identify any action that needed to be taken and who should do this. Information about at-risk patients had been recorded on patients' records where relevant. These arrangements helped to protect patients' welfare because they promoted the sharing of important information between practice and community staff.

Monitoring safety and responding to risk

The practice had arrangements for monitoring safety and responding to changes in risk to keep patients safe. For example, the practice had devised its own health and safety policy setting out the steps it would take to protect staff and patients from the risk of harm or accidents. The practice had a process in place for reporting faults and defects. There was a designated health and safety lead that carried out a monthly risk assessment covering such areas as the safety of the building and equipment. A repairs and renewal spread sheet included details of action taken to address reported faults. Safety certificates confirmed that electrical, gas and medical equipment was safe to use across all three sites. Steps had been taken to control risks from exposure to Legionella which is a bacterium that can cause pneumonia and flu type illnesses. Arrangements had been made to protect patients and staff from harm in the event of a fire. This included carrying out appropriate fire equipment checks.

The practice had a business continuity and recovery plan which included an assessment of potential risks that could affect the day-to-day running of the practice. This provided information about contingency arrangements that staff would be expected to follow in the event of a foreseeable emergency. The practice manager told us they had assessed current risks and had taken steps to minimise any identified risks. This showed that the provider had taken steps to keep patients safe and free from harm and ensure the continuity of the service in the event of an emergency.

Medicines management

Brampton Medical Practice and its branch surgeries offered a dispensing service to those patients who lived more than 1.5 miles from a pharmacy. The practice employed a large team of dispensary staff who worked over three sites, including a medicines manager, 14 dispensing staff, two trainee dispensers and dispensary reception staff. In addition, staff in the dispensary are supported by two dispensers who have been given a temporary supervisory role. One of these staff members is the deputy team leader. The whole dispensing team is also supported by a GP lead who has specific non-clinical time set aside weekly for managerial supervision as well as day-to-day management

cover provided by the Practice Manager. We spoke with some of the patients who attended the practice on the day of our inspection. All were satisfied with the dispensing service they received.

Arrangements were in place which helped to ensure that staff learnt from 'near misses' and medicine errors. We saw steps had been taken to improve prescribing and prevent errors, by carrying out specific audits. For example, a monthly audit was carried out to make sure any changes to prescribing during a patient's stay in hospital were noted. Changes made to medicines in hospital were reviewed and electronically stamped by the patient's GP before the practice's IT system was amended. Another audit was carried out to help ensure that patients prescribed a medicine to treat episodes of manic depression had blood tests carried out every three months. A system was also in place to follow up such patients when they did not attend for a blood test. Dispensary staff had access to on-line patient information leaflets which provided the most up-to-date information about medicines they were dispensing.

All dispensed medicines were double checked by dispensing staff. However, we also saw a patient being given their prescribed medicine without the dispensary receptionist checking that they understood how to take it correctly. Providing patients with appropriate guidance helps to ensure that they know how to take their medicines safely. Processes were also in place which helped the practice to monitor any prescriptions not picked up by patients to allow for follow up action to be taken if needed.

In the main surgery's dispensary, we saw that it was custom and practice for prescriptions to be dispensed and the medicines given to patients before the prescription had been signed by the prescriber. Any variation in a patient request for medicines on a repeat prescription was sent to a GP on an electronic task for authorisation before dispensing. Staff at one of the branch surgeries told us they would not dispense a medicine unless a GP had first authorised any changes to the prescription. Although the practice told us systems had been put in place to help mitigate any prescribing risks associated with their current procedures for handling prescriptions, the failure to sign prescriptions prior to dispensing is in contravention of relevant legislation and is an unsafe practice.

We saw oxygen cylinders had been stored in an area adjacent to a potential combustible material. There was no warning sign that a hazardous product was stored in the area. Storing oxygen near flammable material is a potential fire hazard.

We looked at the arrangements the practice had put in place to check that dispensing staff had the right competencies and knowledge to perform the tasks and roles assigned to them. All dispensary staff were trained (to varying levels) and some dispensers were very experienced. When we looked at staff training files we found that staff in the dispensary had not received an annual appraisal in the past 15 months, or in some cases much longer. Failure to re-assess the competency of staff and support their personal development could put patients at risk of receiving incorrect medicines.

We reviewed the arrangements for storing and transporting vaccines. We found regular checks of refrigerator temperatures had been completed, to make sure vaccines were stored at the correct temperature at the main and branch surgeries. Guidance was available informing staff of what action to take if the refrigerators failed. We were told that vaccines were transported from the main practice to the branch surgeries by medical staff. No arrangements were in place to maintain the 'cold chain' during these journeys. (A cold chain is an uninterrupted series of storage and distribution activities which ensure and demonstrate that a medicine is always kept at the right temperature) Although these journeys were no more than five miles long, the failure to maintain an unbroken 'cold chain' placed patients at risk of receiving ineffective vaccines. Although the practice had already identified this as a concern, it had not yet been addressed. Records were kept when medicines were received into the main practice and sent out to the branch surgeries. Details of the controlled drugs (CDs) being transported were entered in the dispensary CD register. (Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled drugs.) However, dispensing staff at the branch surgeries did not keep a written record of medicines they returned to the main practice. We were told dispensers at the branch surgeries usually phoned the main practice to let them know patient returned medicines or unwanted stock were on their way. The absence of a robust audit trail might mean that staff might be unable to account for any medicines that went missing.

Are services safe?

We identified that the practice had a lot of patient returned medicines requiring disposal. These were in bins supplied by the licensed waste carrier and in other containers in an area with restricted access, but outside the dispensary. There was also a large quantity of CDs awaiting de-activation and disposal. All CDs were kept in locked cupboards within the dispensary. Records showed that the destruction of CDs returned by patients had last taken place in April 2013. Not disposing of unwanted or date expired medicines promptly increases the risk of mishandling or misuse. Otherwise, there were appropriate arrangements in place for storing medicines that required cold storage and for carrying out medicines stock control.

Cleanliness and infection control

The practice was visibly clean and hygienic throughout. All of the patients we spoke with told us the practice was clean and hygienic. Overall, suitable arrangements had been made which ensured the practice was cleaned to a satisfactory standard. For example, the practice employed its own cleaning staff at the main site and had recently made arrangements for contract staff to clean the branch surgeries. Staff told us that any shortfalls in the quality of cleaning carried out were immediately addressed with the relevant staff and contractors. Cleaning schedules were available in toilets along with notices to remind patients and staff of the importance of hand washing.

Protective paper covers for consultation couches, personal protective equipment and materials, and bins for clinical and sharps waste, were available in the clinical rooms we visited. Paper screens had been fitted around examination couches in the clinical rooms. Spillage kits were available to enable staff to deal safely with spills of bodily fluids. We identified that cleaning staff were not storing their mops in line with national guidance entitled 'Colour Code for Hygiene'. Using this system helps ensure cleaning equipment is not used in multiple areas, thereby reducing the risk of cross-infection.

Regular checks were carried out to help make sure staff were following the practice's infection control guidance. For example, the practice held five infection control sessions a year to help ensure staff were clear about what was expected of them. Staff said they received regular infection control training. The infection control lead told us a hand hygiene monitoring check was due to be carried out shortly. An infection control checklist was used to help identify any shortfalls or areas of poor practice. We were told that, where concerns were identified, an action plan would be put in place, discussions would take place in staff meetings and information would be shared with the staff team. Infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. These arrangements helped to protect patients and staff from the risk of infection.

Staffing and recruitment

Systems, processes and operating procedures aimed at protecting vulnerable patients were in place. For example, the practice had a robust procedure for recruiting staff which meant there was suitable guidance about how staff should be recruited. We looked at the records of staff that had been appointed since the provider's registration in April 2013. Thorough checks had been undertaken to make sure clinical nursing staff were registered with their professional body, i.e. the Nursing and Midwifery Council, and were fit to practise. We found Disclosure and Barring Service (DBS) checks had been obtained for staff. Written references and full employment histories had been obtained which provided information about staff's previous periods of employment. NHS Smart cards contained a recent identification photograph and staff's identity had been checked via the DBS application process. This helped to ensure that only suitable staff were employed to work at the practice.

Dealing with Emergencies

Systems were in place which helped with the understanding and management of foreseeable risks. The practice's business recovery continuity plan set out the alternative arrangements that would be put in place if, for example, the premises became unusable for any length of time. The plan had been reviewed during the last 12 months to make sure it was up-to-date. The practice had appropriate equipment for managing emergencies. This included medication and resuscitation equipment. Regular recorded checks of the emergency drugs, the defibrillator and oxygen supply were carried out which helped to ensure they were safe to use. Staff knew where to access the practice's resuscitation equipment and checks were completed to make sure it was kept in good working order. Staff told us they were clear about the action to take in the event of a medical emergency. All relevant staff had completed Cardio Pulmonary Resuscitation (CPR) training during the previous 12 months. Each clinical room had a 'panic button' call system which could alert colleagues in

Are services safe?

the event of an emergency. Staff were also able to send out a panic alert on the practice intranet system. These arrangements helped to protect patients from the risk of harm in the event of a foreseeable emergency.

Are services effective?

(for example, treatment is effective)

Summary of findings

Arrangements for making sure services were delivered effectively had been put in place. Care and treatment was being delivered in line with current published best practice. A clinical audit system aimed at improving clinicians' practice was in place. Action had been taken to help ensure the practice was able to provide effective care to its key patient groups, including those with long term conditions and older people. Feedback from patients was mostly positive about the care and treatment they received.

Our findings

Promoting best practice

Patients' needs were assessed and their care and treatment was delivered in line with current legislation and standards. The staff we spoke with told us the care and treatment they provided was evidence based and informed by relevant quality standards, such as those provided by the National Institute for Health and Care Excellence (NICE.) We confirmed that clinical staff had access to relevant national and local guidance and care pathways.

Arrangements were in place which ensured informed consent was obtained for the care and treatment provided to patients. Guidance was available to clinicians about how they should seek informed consent from patients, including children, who might find it difficult to provided valid consent. Staff told us they never provided any care and treatment without first seeking the patient's permission. This helped to ensure that patients' right to refuse care and treatment were respected.

Management, monitoring and improving outcomes for people

We found outcomes for patients who used the practice were mostly in line with expected norms. We looked at the Quality Outcomes Framework (QOF) for this practice. (The QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients.) The latest available performance data showed the practice had, for the most part, achieved good outcomes for its patients. This showed the practice had not only produced registers which identified patients suffering from a range of chronic diseases, such as asthma and coronary heart disease, but had also delivered healthcare interventions in line with nationally accepted clinical guidelines.

The practice manager told us the practice management team was responsible for providing complete, accurate and timely performance information to enable QOF data to be submitted, and that robust systems were in place to enable this to happen. The practice manager acknowledged there was still room for improvement. For example, we were told steps were being taken to streamline the recall of patients on multiple disease registers so that they only had to attend one appointment rather than being asked to attend a number of different appointments.

Are services effective?

(for example, treatment is effective)

Arrangements had been made to care for patients with mental health needs, mothers, babies and children, and patients requiring palliative care. (Palliative care aims to alleviate pain and discomfort to improve quality of life for all patients with any end stage illness.) We saw the practice had achieved almost all of the QOF points available to them indicating they had taken steps to achieve good patient outcomes and provide good quality clinical care. For example, most patients on the mental health register had a comprehensive care plan in their records which had been agreed with them and their supporters. Good advice about how to access mental health support was available on the practice web site including, for example, details of organisations able to offer help and support such as the Alzheimer's Society. The practice had identified patients in need of palliative care. Regular multidisciplinary case review meetings were held, where the needs of all patients on the palliative care register were discussed. Mothers, babies and children were provided with services which met their needs. This included providing, for example: mothers with ante-natal care and screening in line with local guidelines; women with contraceptive advice; and child development checks at intervals consistent with national guidelines and policy.

The practice carried out clinical audits leading to improvements in the quality of their clinical care.) A clinical audit had recently been carried out to enable an assessment of the quality of surgical practice in relation to vasectomies carried out at the practice.

The practice monitored other aspects of the care and treatment provided to patients. For example, we were shown evidence confirming that in-practice audits were carried out to monitor progress against, and compliance with, the QOF.

Staffing

Staff employed to work within the practice were appropriately qualified and competent to carry out their roles safely and effectively. The practice was designated as a training practice for GP Registrars (GPRs) and had three designated GPR trainers. We were told a named GP was available every day to provide GPRs with supervision and support.

The partnership was stable and many staff had worked at the practice for a considerable amount of time. We were told practice staffing levels were subject to constant review to ensure they remained relevant and appropriate. We were told the practice would soon be down a GP, but that steps had already been taken to recruit a replacement.

Clinical staff had developed special interests which helped to ensure that patients' needs could be met by practice staff. For example, a vasectomy clinic was held by one of the partners who had a special interest in this area. Other GPs at the practice had a range of specialist interests covering such areas as mental health, minor surgery, sexual health and dispensing/prescribing.

Arrangements were in place to provide staff with opportunities for continued learning, including protected time, provision of appraisals and attendance at practice/clinical meetings. The practice had an appropriate induction programme which staff were expected to complete. A completed induction record was in place for a recently appointed GP. We looked at a sample of other records which confirmed staff received an induction and support to learn about their new role and responsibilities.

Working with other services

The practice had made arrangements to promote multidisciplinary working with other services. For example, district nurses and health visitors were invited to attend practice team meetings and other relevant meetings. This helped to promote the sharing of relevant information and consensus over any action that needed to be taken regarding patient care. One of the GPs represented the practice at local Clinical Commissioning Group level enabling them to contribute to the development of healthcare services within the locality. The practice had agreed to participate in a pilot led by the Cumbria Clinical Commissioning Group that was aimed at bringing together health and social care community services to help improve the general health and wellbeing of communities in Carlisle. This showed the practice had taken steps to improve the quality of care provided to patients by contributing to the development of better collaborative working between relevant professionals, such as community nurses and health visitors.

Health, promotion and prevention

Arrangements had been made to support people to live healthier lives. Health promotion work was carried out by the practice nurse team. The staff we spoke with demonstrated a commitment and dedication to achieving the best possible outcomes for their patients. Nursing staff

Are services effective?

(for example, treatment is effective)

were clear about their roles and responsibilities, and said they had the skills, knowledge and competencies required to carry out health promotion and preventive care and treatment. The practice provided a range of services and clinics, and other specialist services. Information about the services provided was available on the practice web site. Information relating to health promotion was also available in the main practice site reception area. New patients were offered a health assessment on registering with the practice, which included a review of their current health and lifestyle. The practice recently took part in a local initiative to help counter the flu virus locally and offered flu vaccines to primary school aged children. The practice website included information about how to access appropriate influenza advice and support.

Are services caring?

Summary of findings

Patients were treated with kindness, dignity and respect and their privacy was promoted. The majority of patients told us they were satisfied with the care and treatment they received from the practice. The most recent in-practice survey confirmed this. Patients were involved in planning and making decisions about their care and treatment, and where appropriate, they were supported to provide informed consent.

Our findings

Respect, dignity, compassion and empathy

Patients were treated with kindness, dignity and respect, and their privacy was promoted, for example, privacy curtains were available in the consultation rooms we visited. A separate room close to the reception area was available, should a patient indicate they wished to speak confidentially about a private matter. A similar facility was available at the branch surgery we visited. The majority of the 14 patients we spoke with said they were treated with dignity, and their privacy was respected.

Reception staff were courteous and spoke respectfully to patients at all times. They listened to patients and responded appropriately. Of the patients who participated in the National GP Patient Survey in 2013, 96% said they found receptionists at the practice 'helpful'. A similar high level of satisfaction was found when respondents to the in-practice patient survey were asked about the reception team. Out of the respondents who participated, the majority said the reception team was 'helpful', and 98.5% of patients said staff were 'polite' and courteous'.

Arrangements were in place to offer patients the option of having a chaperone present during their consultation. Of those patients who answered our question about the use of chaperones in the in-practice patient survey, most said a chaperone had been offered. Information about how to access a chaperone was available in the practice and on the practice web site. All staff, including GPs, had received chaperone training.

Arrangements had been made to provide patients with the support they needed to cope emotionally with their care and treatment. Of the respondents to the in-practice patient survey, 92.8% of patients said they were given enough time to discuss what they wanted at their appointment and 94.4% said they felt they were listened to. A similar high level of satisfaction was expressed with regards to the nursing team. Some of the patients we spoke with said they had been referred to various support groups and had been provided with printed information about their healthcare condition. Information about a range of various support groups was available on the practice website.

Are services caring?

Involvement in decisions and consent

Patients were supported to express their views and were involved in making decisions about their care and treatment. Of the patients who participated in the National GP Patient Survey in 2013, 77% of respondents said the GP they visited had been 'good' at involving them in decisions about their care. Of the respondents to the in-practice patient survey, 95.7% said their GP had satisfactorily explained their condition and the treatment they needed. A similar high level of satisfaction was noted in relation to the care and treatment provided by nurses. Of the 14 patients we spoke with, 13 said they had been involved in decisions about their care and treatment, and that staff had taken time to explain things in an understandable manner.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider understood the diverse needs of the population it served and had made arrangements for these to be met. Systems were in place to obtain feedback from patients regarding the quality of the service they received from the practice. This was used to inform planning aimed at improving the care and treatment provided to patients. Improvements were being introduced to enable the practice to be more responsive to patients' needs.

Our findings

Responding to and meeting people's needs

The provider understood the diverse needs of the population it served and took action to provide what patients needed. The practice had adopted a LEAN approach to reviewing the quality of the services it provided. (LEAN is an approach that can be used to provide patients with better quality care by focussing on the more effective use of resources and the reduction of waste.) We were told this approach had resulted in significant improvements being made, including, for example, the new telephony system which was due to be installed. The practice manager spoke clearly about the improved information they would receive, such as the number of calls abandoned and how long patients had waited before terminating their call, and how this information would be used to improve the service.

We looked at how the practice met the needs of older people. We saw the practice provided patients with a holistic evidence-based approach to the management of their long term conditions. This included a system that recalled patients on their birthday for a comprehensive review of their health and wellbeing. Patients were also provided with information, advice and support to make appropriate lifestyle choices and changes. The majority of patients who responded to the recent in-practice survey said they felt staff provided good advice which helped them to manage their health condition. Most of the patients we spoke with provided us with similar feedback.

We also looked at the steps the practice had taken to manage the needs of vulnerable older patients needing end of life care, who were at-risk of unplanned admission into hospital. A register was in place to record such patients who were at risk. Plans had been made to write to each patient who had been placed on a register to let them know what action the practice was taking to help reduce the risk of their admission into hospital, including the provision of a suitable care plan. (GP practices use registers to record such information as how many patients have a specific disease or condition.)

The practice operated a personal list system which meant each GP was responsible for all of their allocated patients

Are services responsive to people's needs?

(for example, to feedback?)

within working hours. This system can help GPs to develop a much closer working relationship with their patients and meant each patient had a nominated GP who was responsible for their care.

The practice had made arrangements which helped to remove barriers which some patients faced when accessing or using the service. A small group of travellers were registered with the practice. The practice was aware of the needs of this group of patients. For example, patient records contained alerts to notify staff when baby vaccinations were due. A system was in place to follow up non-attendance, and the practice nurse was notified of any concerns. Patients were reminded of appointments via the mobile text service the practice used. The practice website provided new patients with good information about how to register, including a link to The Royal College of General Practitioners publication, 'A Patient Guide to GP Services'.

Staff understood the lifestyle risk factors that affected some groups of patients within the practice population. We were told the practice provided a range of services and clinics that were aimed at helping particular groups of patients to improve their health. For example, the practice provided patients with access to smoking cessation, weight and diet advice and sexual health clinics, and services aimed at promoting women's health and wellbeing. We found that the majority of patients on the practice heart disease register had been given lifestyle advice, including how they could increase physical activity, stop smoking, eat a healthy diet and consume alcohol safely.

Reasonable adjustments had been made which helped patients with disabilities, or whose first language was not English, to access the service. For example, a consultation room and small reception area were available on the ground floor. Access to an interpreter service was available for use by patients whose first language was not English. Patients with physical disabilities were able to access the main practice building, although we identified that further improvements could be made. For example, one patient with a physical disability told us they found some of the doors in the practice difficult to open. The disabled toilet did not contain an emergency buzzer to alert staff in the event of an emergency. For the most part, patients with disabilities, and those whose first language was not English, were able to access the healthcare they needed because the practice had made 'reasonable adjustments' to help them to do so. The practice manager acknowledged that further improvements could be made.

Access to the service

The practice supported patients to receive a timely and accurate diagnosis, either directly from the practice or by referral to a specialist. Arrangements had been made which helped to ensure that test results were followed up in a timely manner. The majority of patients who responded to the in-practice survey said that the arrangements for providing or arranging for treatment to be provided for them were 'good'.

The practice was in the process of reviewing the responsiveness of its appointment system. We were told significant changes had been made which the practice hoped would provide patients with more choice and improved access. For example, a new telephone system was about to be installed. We were told this would enable the practice management team to obtain accurate patient access information to help them make more informed decisions about how to meet the demand for same-day urgent care and the booking of routine appointments.

The practice offered patients different ways of accessing appointments. For example, we were told patients were able to book appointments up to three weeks in advance at any time of the day as well as 'bookable on the day' appointments. The practice operated a duty doctor system. This clinician was responsible for reviewing all incoming requests for same-day urgent care. Where possible, patients requesting same-day urgent care were fitted into urgent slots with their own GP. We were told that once all of these appointment slots had been filled, the duty doctor would then deal with all such requests. This enabled the practice to respond more flexibly to patients with urgent same-day care needs requesting immediate appointments, including requests for home visits. The practice manager undertook weekly capacity reviews (looking at what staff were available for the coming week) and was clear about the number of appointments needed to meet predicted levels of demand (numbers of appointments needed.) The practice was in the process of installing a patient self check-in screen to help reduce the pressure on the reception team. Patients were able to book appointments on-line.

Are services responsive to people's needs?

(for example, to feedback?)

Of the patients who participated in the National GP Patient Survey, 83% said they found it 'easy' to get through to someone at the practice. 93% of respondents also said they were able to see or speak to their preferred GP and the practice opened at times that were convenient to them. We also found a high level of satisfaction regarding open hours had been expressed by the majority of patients who had responded to the in-practice patient survey. We saw that the practice opened on a Saturday morning to help meet patient demand for appointments outside of working hours. Most respondents to the in-practice survey said they found getting through to the practice was 'easy'.

We talked to 14 patients about their experience of using the practice. We also received one patient comment card. Whilst the majority of patients we spoke with expressed no concerns about getting through to the practice on the telephone, 42% said they had experienced difficulties in this area. Also, whilst some patients said they had experienced no difficulty obtaining an appointment, 71% said they had experienced problems, and 21% said they had found it problematic to obtain an appointment in advance.

Of the respondents who completed the practice's in-patient survey, the majority said they either waited 'less than five minutes' or 'between five and 10 minutes'. A smaller proportion of patients said they waited between '11 and 20 minutes'. None of the patients we spoke with mentioned concerns about appointment waiting times. We viewed the appointment waiting times for six patients on the day of our inspection. We found that three had been kept waiting for more than ten minutes. However, reception staff told us that patients were kept informed if surgeries were running late. For example, receptionists inform patients when they arrive if there are more than two patients waiting to be seen before their appointment.

The practice's brochure provided information about, for example, the range of services offered and how patients could obtain medical support outside of surgery hours. Health promotion literature, and information about services provided at the practice, was available in the reception area. The practice website provided patients with information about opening hours, how to obtain repeat prescriptions, and what to do in an emergency. These arrangements helped to provide patients with appropriate information about what the practice provided and how they could promote their own health and wellbeing. Practice staff had access to an interpreting service to help ensure that patients whose first language was not English could understand the care and treatment options available to them.

Concerns and complaints

The practice had a clear complaints policy which set out how complaints would be handled. We saw the policy did not include a specific timescale within which complaint outcomes would be communicated to complainants. The policy told patients that outcomes would be shared within a, 'relevant period, i.e. six months'. Information about how to make comments or suggestions had been included on the practice website. Information about how to complain had been included in the practice leaflet and was available in the practice. We looked at the complaints log for the previous 6 months. We were able to see that the practice had taken action to deal with the eight complaints it had received.

Are services well-led?

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

Summary of findings

There was a strong and visible leadership team with a clear vision and purpose. Governance structures were, overall, robust and there were systems in place for managing risks. However, we found there was a lack of supervision and managerial support for staff working in the dispensaries.

Our findings

Leadership and culture

There was a clear focus on promoting clinical excellence and staff demonstrated a commitment to achieving the best possible outcomes for patients, whether this was during patient consultations, or in the way they delivered services to patients in hard to reach groups or with complex long term conditions. The service operated an open culture and actively sought feedback from staff and promoted their engagement in helping to improve the services they provided to patients. There was a well-established management structure with clear allocations of responsibilities, such as lead roles. Staff demonstrated a good understanding of their areas of responsibility and took an active role in trying to ensure patients received good care and treatment.

Governance arrangements

Governance arrangements were mostly effective and supported transparency and openness. We found care and treatment was provided by a multidisciplinary team in which full use was made of all the team members. Systems were in place to keep staff at all levels informed about what was happening in the practice and to ensure they worked together to identify and help implement improvements. For example, GP associates met with the lead GP every two months. Monthly clinical meetings were also held. Holding regular meetings helps to create a sense of awareness and ownership within the team. We also found that leads had been identified for a range of clinical and non-clinical areas. Taking on lead GP roles helps to provide team members with leadership and support as they carry out their day-to-day work. Regular reviews of patient and performance data were carried out. For example, checks were carried out to monitor the number of new patients who received an alcohol screen as part of the New Patient Health Check. Carrying out such reviews provided factual information about how well the practice provided essential and additional services for their patients, and to reach informed decisions about what steps might be necessary to improve performance. However, although the practice had made arrangements for two dispensary staff to take on a temporary supervisory role with increased pay, we found some dispensing staff had not undergone an annual appraisal in the past 15 months or in some cases much longer.

Are services well-led?

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

Systems to monitor and improve quality and improvement

A range of systems were in place to monitor and improve quality and improvement. The practice had a data entry protocol which provided doctors and nurses with comprehensive guidance about how they should capture all patient contacts and other significant health events such as referrals, test results and discharge information. Staff were aware of which staff had responsibility for ensuring that patient information, and outcomes of consultations, was correctly coded. The practice manager told us this helped ensure the practice was able to submit accurate information to external bodies reporting on performance in a timely way. We were shown evidence which confirmed regular audits were undertaken to ensure data quality was maintained to a good standard.

Patient experience and involvement

An external organisation had carried out an in-practice survey in 2014 which sought patients' opinions about how well Brampton Medical Practice cared for them. The survey covered such areas as satisfaction with the performance of the doctors and nurse through to whether opening times were convenient. The majority of patients who responded to the survey described their experience of using the practice was 'good'. Over 97% of respondents said they would recommend the practice to someone who had just moved into the area.

The majority of patients we spoke with on the day of our visit said they were satisfied with the care and treatment they received from practice staff. However, whilst the majority of patients we spoke with expressed no concerns about getting through to the practice on the telephone, 42% said they experienced difficulties in this area. Whilst some patients said they had experienced no difficulty obtaining an appointment, 71% said they had experienced problems. Also, 21% of the patients we spoke to said they found it difficult to book appointments in advance. We were told the results of the survey had been considered by the partners and practice management team, and an action plan had been formulated to help address these concerns.

The practice had an active Patient Participation Group (PPG) whose members chose to contribute either by attending planned meetings in person or by commenting via email. We saw evidence confirming the practice had sent targeted invitations to patients that were under-represented in the PPG either by age or ethnicity. We could see some progress had been made, but the practice manager acknowledged further work was needed to increase representation on the PPG so that it better reflected the practice's population profile. PPG meetings took place on a regular basis with the most recent meetings taking place in March 2014 and November 2013. The last PPG meeting minutes showed that attendees had been given the opportunity to express their views on the outcome of the latest in-practice survey results. PPG members and practice staff had developed a set of priorities which set out what improvements were needed, how these were going to be met and by when. The practice web site also included information about how patients could express an interest in joining the PPG. The arrangements made by the practice helped to ensure patients had their views and experiences taken into account in the way their care and treatment was provided.

Staff engagement and involvement

The staff we spoke with said they were committed to working well together as a team. They said the whole team worked together in a positive manner to deliver good patient care. Staff said their opinions were sought and they confirmed they felt involved in how the practice was managed and services were delivered. An established system of practice and clinical meetings was in place, and staff said this enabled them to hear about proposed changes and provide feedback, and to share information about what had happened to them in their day-to-day practice. Minutes of meetings were kept so that all members of the team knew what issues had been discussed and what action points had been agreed. These arrangements helped to promote the involvement of staff in the day-to-day running of the practice.

Learning and improvement

Staff were provided with opportunities to continuously learn and improve. They told us they were provided with lots of opportunities for continuous learning which enabled them to retain their professional registration or be successful in attaining revalidation. They said personal development was both encouraged and supported. Staff, including practice nurses, said 'protected learning time' sessions took place on a regular basis enabling them to complete required training and obtain evidence for their continuing professional development. The practice

Are services well-led?

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

demonstrated their strong commitment to learning by providing opportunities for GP registrars to complete their training. These arrangements helped to promote and support staff learning and improve performance.

Identification and management of risk

Management systems were in place which enabled learning and improved performance. The team worked well together to address and resolve problems in the delivery of good patient care. Clinical staff participated in regular meetings where discussions took place about any concerns or significant events. The staff we spoke with told us the team worked well together to address and resolve the problems they encountered during their day-to-day work. Staff were able to tell us about improvements that had been made following the significant event reviews they had carried out. All patients told us they felt safe using the service. These arrangements promoted staff learning and contributed to the delivery of safe patient care.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of Medicines Patients were not always protected from the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines were not always stored or transported safely. Appropriate arrangements were not in place for prescribing medicines. Medicines were not disposed of appropriately.