# 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.

## 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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# Summary of findings

## Overall summary

### Letter from the Chief Inspector of General Practice

We inspected the practice on 12 November 2014. We inspected this service as part of our new comprehensive inspection programme. Overall, we rated the practice as good. Specifically, we found the practice to be good for providing effective, caring, responsive and effective services, but as requiring improvement for providing safe services. It was also good for providing services for the six key population groups.

Our key findings were as follows:

- Patients reported good access to the practice, including the provision of same day appointments and access to clinical advice and support for those with urgent care needs;
- Patients reported they were treated with kindness and respect, and received safe care and treatment which met their needs;
- Patient outcomes were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area;
- Practice staff followed guidance produced by the National Institute for Health and Care Excellence (NICE) when providing care and treatment to patients;
- The practice was clean and hygienic, and good infection control arrangements were in place;
- The practice learned from significant events and incidents and took action to prevent their recurrence.

Importantly, the provider must:

- Ensure patients are protected from the potential risks associated with medicines. The provider must put appropriate arrangements in place to manage medicines: repeat prescriptions must be signed before dispensing takes place; medicines must be stored or transported safely; medicines must be disposed of appropriately. (Regulation 13 of the Regulated Activities Regulations (2010).)

**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 as there are areas where it should make improvements.

The practice had demonstrated most aspects of the care and treatment it provided were safe. Staff understood and fulfilled their responsibilities with regard to raising concerns, recording safety incidents and reporting them both internally and externally. The management team took action to ensure lessons were learned from any incidents or concerns, and shared these with staff to support improvement. A culture of openness operated at all levels in the practice, which encouraged the reporting of errors and 'near misses'. Safe staff recruitment practices were followed and there were enough staff to keep patients safe. Good infection control arrangements were in place and the practice was clean and hygienic. Risks to patients were assessed and well managed. However, the provider had not fully complied with the compliance action we set following our last inspection, regarding some aspects of how medicines were managed. We have therefore repeated the original compliance action we set under Regulation 13 of the Regulated Activities Regulations (2010), in order to provide the practice with additional time to comply.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services.

Nationally reported data showed patient outcomes for effective were either in line with, or better than average, when compared to other practices in the local Clinical Commissioning Group (CCG) area. Patients' needs were assessed and care was planned and delivered in line with current legislation and best practice guidance produced by the National Institute for Health and Care Excellence (NICE.) Staff had received training appropriate to their roles and responsibilities. Arrangements had been made to support clinical staff with their continuing professional development. There were systems in place to promote effective multi-disciplinary working with other staff in the area. Staff had access to the information they needed to deliver effective care and treatment.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services.

Nationally reported data showed patient outcomes for caring were, for the most part, in line with other practices in the local CCG area. Patients said they were treated with compassion and were involved

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in making decisions about their care and treatment. Arrangements had been made to ensure their privacy and dignity was respected. Patients had access to information and advice on health promotion, and they received support to manage their own health and wellbeing. Staff demonstrated they understood the support patients needed to cope with their care and treatment.

**Are services responsive to people's needs?**

Good

The practice is rated as good for providing responsive services.

Nationally reported data showed patient outcomes were mostly in line with the performance of other practices in the local CCG area. Services had been planned so they met the needs of patients, including older people and those with long-term conditions. Patients were able to access appointments in a timely way and reported good access to the practice. The practice had taken steps to reduce emergency admissions to hospital for patients with complex healthcare conditions, and older patients had been allocated a named GP to help promote continuity of care. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system and evidence that the practice responded quickly to any issues raised.

**Are services well-led?**

Good

The practice is rated as good for providing well-led services.

The leadership, management and governance of the practice assured the delivery of person-centred care which met patients' needs. The practice had a clear vision for improving the service and promoting good patient outcomes, including plans to provide patients with access to their medical records. Staff were clear about their roles and understood what they were accountable for. They also said they felt well supported. The practice had a range of policies and procedures covering its activities, and these were regularly reviewed. Systems were in place to monitor, and where relevant, improve the quality of the services provided to patients. The practice actively sought feedback from patients and used this to improve the service it provided. Although an effective governance framework was in place, the practice had not taken appropriate action to address all aspects of the compliance action we issued in relation to the management of medicines.

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## 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 patients.

Nationally reported data showed the practice had achieved good outcomes in relation to the conditions commonly associated with older people. The practice offered proactive, personalised care to meet the needs of older people. It provided a range of enhanced services including, for example, end of life care and a named GP who was responsible for coordinating their care.

**People with long term conditions**

Good

The practice is rated as good for the care of patients with long-term conditions.

Nationally reported data showed the practice had achieved good outcomes in relation to those patients with commonly found long-term conditions. The practice had taken steps to reduce unplanned hospital admissions by improving services for patients with complex healthcare conditions. Patients on the practice's long-term conditions registers received healthcare reviews that reflected the severity and complexity of their needs. Person-centred care plans had been completed for each patient. These included details of the outcome of any assessments patients had undergone, as well as the support and treatment that would be provided by the practice.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people.

Nationally reported data showed the practice had achieved good outcomes in relation to child health surveillance, contraception and maternity services. Systems were in place for identifying and following-up children who were considered to be at risk of harm or neglect. Arrangements had been made for new babies to receive the immunisations they needed. Access to a weekly midwifery clinic was provided.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the population group of working-age patients (including those recently retired and students.)

The needs of this group of patients had been identified and steps taken to provide accessible and flexible care and treatment. The

# Summary of findings

practice was proactive in offering on-line services to patients. Repeat prescriptions could be ordered, and appointments booked, on-line. Appointments were available until 6.30pm each weekday and an extended hours service was provided each Saturday morning at the main practice site. Health promotion information was available in the waiting area and on the practice web site. The practice provided additional services such as travel information and vaccinations, smoking cessation support, counselling and well women/men clinic appointments.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable.

The practice had achieved good outcomes in relation to meeting the needs of patients with learning disabilities. The practice held a register which identified which patients fell into this group, and used this information to ensure they received an annual healthcare review and access to other relevant checks and tests. Staff worked with multi-disciplinary teams to help meet the needs of vulnerable patients. The practice sign-posted vulnerable patients to various support groups and other relevant organisations. Staff knew how to recognise and report signs of abuse in vulnerable adults and children.

**People experiencing poor mental health (including people with dementia)**

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including people with dementia).

The practice had achieved good outcomes in relation to meeting the needs of patients with mental health needs. The practice kept a register of these patients which it used to ensure they received relevant checks and tests. Where appropriate, a comprehensive care plan had been completed for patients who were on the register. The care plans had been agreed with the patients and their carers. The practice worked with multi-disciplinary teams to help meet the needs of patients experiencing poor mental health.

# Summary of findings

## What people who use the service say

During the inspection we spoke with five patients. We received no completed Care Quality Commission (CQC) comment cards. The feedback we received indicated most patients were satisfied with the care and treatment they received. Patients told us they received a good service which met their needs. They said they were treated with dignity and respect and they felt their privacy was protected. We received positive feedback about the practice's appointment system and patients told us they found it easy to get through to the practice on the telephone. Patients said they were able to obtain an appointment within a reasonable amount of time.

Findings from the 2014 National GP Patient Survey of the practice indicated a high level of satisfaction with the care and treatment it provided. For example, of the patients who responded:

- 85% said they found it easy to get through to the practice by telephone;
- 98% said they found the receptionists at the surgery helpful;
- 97% said they were able to get an appointment to see or speak to someone the last time they tried to do this;
- 98% said the last appointment they got was convenient;
- 88% said they were satisfied with the practice's opening hours;
- 90% said they would recommend the surgery to someone new to the area.

All of the above results were higher than the Clinical Commissioning Group (CCG) regional averages. These results were based on 137 surveys that were returned from a total of 255 sent out. The response rate was 54%.

Results from a survey of 345 patients carried out by the practice in 2014 showed the majority of patients were satisfied with the arrangements the practice had made for meeting their needs and 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.

## Areas for improvement

**Action the service MUST take to improve**

**Action the provider must take to improve:**

- Ensure repeat prescriptions are signed before medicines are dispensed and given to patients;
- Ensure there is an unbroken 'cold chain' when transporting vaccines;
- Carry out an assessment of dispensing staff's competency to dispense medicines;
- Ensure controlled drugs returned by patients are kept in a secure cupboard and destroyed promptly.

# Brampton Medical Practice

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector, a CQC Pharmacist Inspector and a GP. The team included a specialist advisor with experience of GP practice management.

## Background to Brampton Medical Practice

Brampton Medical Practice is a busy rural dispensing practice which provides services across three sites. The practice is based in Brampton and covers approximately 400 square miles. It provides services to 15,200 patients of all ages, based on a General Medical Services (GMS) contract agreement for general practice. The practice also provides a GP service, under contract, to the Brampton Cottage Hospital. The numbers of patients registered is steadily increasing at a rate of between 50 to 70 patients each year. The practice is part of NHS Cumbria Clinical Commissioning Group (CCG). Brampton Medical Practice has a higher percentage of patients in the over 65 age group, and lower levels of income deprivation for both children and older people, when compared to other practices in the local CCG area.

The main practice site is located in the centre of Brampton and occupies a large building over a number of floors. It provides a range of services and clinics, including, for example, clinics for patients with asthma and epilepsy. The practice has eight GP partners (three female and five male), four salaried GPs (two female and two male), a practice manager, a large team of practice nurses and healthcare assistants, as well as management and reception staff. In addition, the practice has a medicines manager, a dispensing team leader, 12 dispensers, a trainee dispenser and three dispensary receptionists. Dispensing services are provided at the main practice site and both of the branch surgeries. One of the GPs provides support to the dispensing team and they have designated hours each week to enable them to do this. The practice manager also provides support to the team.

Brampton Medical Practice operates branch surgeries at the following addresses:

Beech House

Corby Hill

Cumbria

CA4 8PL

Yew Tree Cottage

Wetheral

Cumbria

CA4 8JD

A CQC pharmacist inspector visited the Wetheral branch surgery as part of the inspection.

When the practice is closed patients can access out-of-hours care via Cumbria Health On-Call and the NHS 111 service. An 'extended hours' service is available on a Saturday morning at the main practice site for patients who are unable to attend the practice during its usual opening hours.

# Detailed findings

## Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

When we previously inspected the practice in May 2014 we told the provider they were not compliant with Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines. We said: '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.'

Following the inspection, the provider sent us an action plan informing us what action they would take to comply with the compliance action and when this would happen. During this inspection we checked whether the required improvements had been made.

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

## How we carried out this inspection

To get to the heart of patients' experiences of care, 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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health

Before visiting we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the services it provided. We carried out an announced inspection on 12 November 2014. During this we spoke with a range of staff including: four GP partners; the practice manager; a practice nurse and staff who worked in the reception and dispensing teams. We spoke with a member of the practice's Patient Participation Group (PPG), and five patients who visited the practice on the day of our inspection. We also observed how patients were being cared for and looked at some of the records kept by the practice. No Care Quality Commission (CQC) comment cards had been completed by patients using the practice.

# Are services safe?

## Our findings

### Safe Track Record

When we first registered this practice in April 2013, we did not identify any safety concerns that related to how it operated. Also, the information we reviewed as part of our preparation for this inspection did not identify any concerning indicators relating to the safe domain. However, we set a compliance action following the last visit we carried out in May 2014 in relation to the management of medicines. The CQC had not been informed of any safeguarding or whistle-blowing concerns regarding patients who used the practice. The local Clinical Commissioning Group (CCG) did not raise any concerns with us about how this practice operated.

The practice used a range of information to identify potential risks and to improve quality in relation to patient safety. This information included, for example, significant event reports, national patient safety alerts, and comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. We found the practice culture focussed on learning from mistakes rather than apportioning blame if errors or mistakes occurred.

We saw that records were kept of significant events and incidents. We reviewed a sample of the significant event/ critical incident reports completed by practice staff during the previous 12 months, and the minutes of meetings where these were discussed. For example, a report had been completed regarding a significant event involving the use of two types of medicines, where one had the potential to affect the effectiveness of the other. The event had been discussed at a practice clinical meeting and guidance had been recorded about what action to take to prevent this from happening in the future. These records showed the practice had managed such events consistently and appropriately during the period concerned and this provided evidence of a safe track record for the practice.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The sample of significant events we looked at included details about what the practice had learned from these events, as well as information about the changes that had been introduced to prevent further reoccurrences. We were told that, where significant events or incidents had occurred, these would be discussed at the weekly partners' meeting and/or during the practice's Protected Learning Time (PLT) sessions.

There was evidence appropriate learning from incidents had taken place and that the findings were disseminated to relevant staff. For example, significant events and 'near misses' were discussed at PLT sessions. We were told information about lessons learnt from significant event reviews was also shared with the practice team via email and that completed significant event review forms were stored on the practice intranet.

All of the staff we spoke with were aware of the system in place for raising issues and concerns. The practice also reported incidents to the local CCG, using the local safeguarding incident reporting system. This required them to grade the degree of risk using a traffic light system, and score the potential impact of the incident on patients using their service. Arrangements had been made which ensured national patient safety alerts were disseminated to the relevant staff. This enabled these staff to decide what action should be taken to ensure continuing patient safety.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. Safeguarding policies and procedures were in place. Information about how to report safeguarding concerns and contact the relevant agencies was easily accessible. 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 safeguarding leads were.

Staff had completed appropriate safeguarding training. Dates for refresher child and adult safeguarding training had been planned for 2014, as part of staff's protected learning time. All the 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. The practice nurse we spoke to said they had also completed more in-depth child protection training.

# Are services safe?

Although the majority of staff had completed safeguarding adult training, training records showed some had not. We saw that the Protected Learning Time (PLT) programme for 2014 included sessions covered this area of training.

A chaperone policy was in place and information about this was displayed in the reception area. Chaperone training had been undertaken by all staff who carried out chaperone duties. None of the patients we spoke to could recall being offered a chaperone. However, they all said they would trust staff to provide this service and would feel comfortable using it.

Patients' records were kept on an electronic system. This system stored all information about patients, including scanned copies of communications from hospitals. There was a system on the practice's electronic records to highlight vulnerable patients. Children and vulnerable adults who were assessed as being at risk were identified using READ codes. These codes alerted clinicians to their potential vulnerability. (Clinicians use READ codes to record patient findings and any procedures carried out).

Systems were in place which ensured any incoming safeguarding information was scanned to patients' medical records. We found the GPs actively engaged in both child and adult safeguarding meetings and with other safeguarding agencies such as Barnardos. Arrangements were in place to follow up children who failed to attend appointments to help ensure they did not miss important immunisations. Practice staff used their multi-disciplinary team (MDT) meetings to review each patient considered to be at risk and, where appropriate, to share any relevant information.

### 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. A GP partner supported the dispensing team and they had designated time each week to enable them to do this. The practice manager also provided day-to-day support.

During this inspection, we found medicines in the dispensary were stored in a tidy and well organised way and their expiry dates were regularly checked to ensure they remained effective. Any changes made to patients' prescribed medicines following a stay in hospital were reviewed by their GP before medical records were amended. This helped to reduce the risk of prescription errors occurring. One of the branch surgeries was equipped to dispense medicines into monitored dose system (MDS) packs. Patients who had difficulty remembering or understanding how to take their medicines received MDS packs to help them take their medicines safely. MDS packs awaiting collection were clearly labelled so that each tablet or capsule could be identified.

Following an inspection we carried out in May 2014 a compliance action was set in which we told the provider: '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'.

The evidence we obtained during this inspection on 13 November 2014, indicated the practice had taken steps to address some of the issues we had previously identified. For example, oxygen cylinders had been stored safely in a metal cabinet. Monthly collections of unwanted patient medicines had been agreed with NHS England since our last visit in May 2014. Improved storage facilities for most unwanted patient medicines had also been put in place. We found action had been taken to review the system for the stock control of vaccines stored at each of the branch surgeries. Partner meeting minutes demonstrated that the concerns we raised about maintaining the 'cold chain' when transporting vaccines had been taken seriously. The practice had also requested their supplier to arrange for the delivery of vaccines direct to the branch surgeries. However, we were told the supplier had said this would not be possible. Action had also been taken to provide dispensing staff with an annual appraisal and plans were in place to achieve this by the end of March 2015.

However, we also found that some of the concerns that had led us to issue the compliance action, in May 2014, had not yet been addressed. For example, during this visit, in November 2014, although we were able to confirm trained dispensing staff had received an annual appraisal, we found this had not included an assessment of their knowledge of medicines or competency to dispense. Failure to regularly assess the competency of staff to safely dispense medicines could place patients at risk of harm.

# Are services safe?

We found that arrangements were still not in place to maintain the 'cold chain', or record how long the vaccines being transported from the main site to the branch surgeries, were out of the refrigerator 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 short, failure to maintain an unbroken 'cold chain' potentially placed patients at risk of receiving ineffective vaccines.

We found repeat prescriptions were still being dispensed before a GP had reviewed and authorised them. Staff at the practice with responsibility for repeat prescribing had considered this issue but had not yet decided upon a revised process that did not compromise patient safety. The relevant standard operating procedure (SOP) had not been amended and unsigned repeat prescriptions were still routinely dispensed and given out to patients.

Arrangements had been made for monthly collections of unwanted medicines that patients had brought to the main practice. Most unwanted medicines were now stored safely. Although some unwanted medicines had been disposed of since our last visit in May 2014, there was still a large quantity of these medicines, including controlled drugs, stored at the practice at the time of this visit. We found controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) returned by patients had not been destroyed promptly and were being kept in an insecure cupboard. This meant there was a risk of misuse. However, we did find that controlled drugs for use in the practice were safely stored and recorded appropriately.

### Cleanliness & Infection Control

The premises were clean and hygienic throughout. Patients told us the practice was always clean. Cleaning schedules and notices reminding patients and staff of the importance of hand washing were on display in toilets and other practice areas.

Infection control policies and procedures were in place. These provided staff with guidance about the standards of hygiene they were expected to follow. A comprehensive infection control audit had been completed in 2014 to help identify any shortfalls or areas of poor practice. We saw that, where shortfalls had been identified, the audit included details of the action to be taken to address them, and when this would be reviewed.

One of the practice nurses acted as the infection control lead and provided guidance and advice to staff when needed. Although the majority of staff had completed infection control training relevant to their role, training records showed some had not. We found this shortfall had been identified by the infection control audit and an action plan had been put in place to address this.

The clinical rooms we visited contained personal protective equipment such as latex gloves, and there were paper covers and privacy screens for the consultation couches. Arrangements had been made for the privacy screens to be changed every six months.

Spillage kits were available to enable staff to deal safely with spills of bodily fluids. Sharps bins were available in each treatment room to enable clinicians to safely dispose of needles. The bins had been appropriately labelled, dated and initialled. These rooms also contained hand washing sinks, antiseptic gel and hand towel dispensers to help clinicians follow good hand hygiene practice.

Arrangements had been made to ensure the safe handling of specimens and clinical waste. For example, the practice had a protocol for the management of clinical waste and a contract was in place for its safe disposal. All waste bins were visibly clean, foot operated and in good working order.

### Equipment

Staff had access to the equipment they needed to carry out diagnostic examinations, assessments and treatments. Minor surgery was carried out at the practice. We saw there were appropriate arrangements for the disposal of single-use surgical instruments, and for the sterilisation of those which could be used more than once.

Equipment was inspected and regularly serviced. We saw records confirming calibration testing had been carried out during the last six months and all the portable electrical equipment had been tested within the last 12 months. Fire equipment checks were also carried out regularly and a fire drill had recently been undertaken. A fire risk assessment had been completed but it had not been reviewed within the last 12 months.

# Are services safe?

## Staffing & Recruitment

The practice had a recruitment policy which provided clear guidance about the pre-employment checks that should be carried out. Pre-employment checks had been undertaken to help make sure staff were suitable. For example, Disclosure and Barring Service (DBS) checks had been obtained for relevant staff, as had written references and full employment histories. Staff's NHS Smart cards contained a recent identification photograph and their identities had been verified under the NHS Employment Check Standards process. We checked the General Medical and Nursing and Midwifery Councils records and confirmed all of the clinical staff were licensed to practice.

## Monitoring Safety & Responding to Risk

The practice had systems and policies in place to manage and monitor risks to patients and staff. This included a daily walk around the building by a designated member of staff to check for any concerns or hazards. We were told any problems identified were added to a spread sheet which was monitored and actioned by the practice manager. We saw an on-going log was maintained which included details of the action taken to address defects or repairs needed.

The practice had a health and safety policy which provided staff with guidance about their role and responsibilities, and what steps they should take to keep patients safe. A health and safety risk assessment had been completed, and we were told an annual health and safety review was carried out as part of the PLT programme. The premises were safe and free from hazards. None of the patients we spoke to raised any concerns about health and safety.

## Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing that all staff had received training in cardio-pulmonary resuscitation (CPR) provided in-house by one of the practice nurses. We identified some staff's CPR training had not been updated for over 12 months. However, plans were in place to update their training by March 2015.

Emergency equipment was available, including access to oxygen, an automated external defibrillator (used to attempt to restart a person's heart in an emergency) and an emergency medicines kit. The staff we spoke with knew the location of this equipment and weekly checks were undertaken by the nursing team to make sure they were in good working order and fit for purpose.

Emergency medicines were stored securely so that only relevant practice staff could access them. These included medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency oxygen was also available. Arrangements were in place to regularly check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date. Practice staff were aware of where the emergency medicines were kept.

There was a business continuity plan for dealing with a range of potential emergencies that could impact on the daily operation of the practice and its branch surgeries. Mitigating actions had been recorded to reduce and manage the risk. Risks identified included the loss of power and the practice IT system.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The practice staff we spoke with were able to clearly explain why they adopted particular treatment approaches. They were familiar with current best practice guidance, and were able to access National Institute for Health and Care Excellence (NICE) guidelines via the practice IT system. From our discussions with these staff we were able to confirm they completed thorough assessments of patients' needs which were in line with NICE guidelines. Patients' needs were reviewed as and when appropriate. A recent practice clinical meeting included an item where one of the GPs had presented an update on NICE cholesterol management guidelines.

Clinical responsibilities were shared between the GP partners and the practice nursing team. For example, one GP partner acted as the lead for drugs and alcohol misuse. Another GP held lead responsibility for overseeing the work of the nursing team. Clinical staff we spoke with were very open about asking for and providing colleagues with, advice and support. For example, a practice nurse told us they felt well supported and received the help and guidance they needed to carry out their role and responsibilities.

Nationally reported data, taken from the Quality Outcomes Framework (QOF) for 2013/14, showed that overall the practice had achieved 95.7% of the total points available to them for delivering best practice clinical care. This achievement was above both the local CCG and the England averages when compared to other practices. (The QOF is a voluntary incentive scheme for GP practices which rewards them for how well they care for patients.)

Clinical staff had access to a range of electronic care plan templates and assessment tools which they used to record details of the assessments they had carried out and what support patients needed. For example, the GP partners used a standardised dementia screening tool to help identify and treat patients with potential cognitive impairments.

Practice staff had the knowledge, skills and competence to respond to patients' needs. The practice had a training plan which identified what training would be provided, to whom and when. We saw clinical staff had access to training on, for example, significant event reviews and had attended presentations on particular clinical conditions. A practice nurse confirmed they had all of the training they currently needed to carry out their role, which included training in cervical screening and administering vaccinations and immunisations. They told us they had also completed training updates in other areas such as infection control and safeguarding children and adults. They also said they used their experience and training from previous roles to inform the work they carried out.

Interviews with GP staff and the practice nurse demonstrated the culture in the practice was that patients were referred to relevant services on the basis of need. Patients' age, sex and race was not taken into account in this decision-making.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. For example, the lead GP for dispensing, the medicines manager and senior dispensary staff, were responsible for monitoring the effectiveness of medicines management. The practice had designated lead clinicians for safeguarding and for clinical conditions covered by QOF. The practice manager and GP partners monitored how well the practice performed against key clinical indicators such as those contained within the QOF.

Training practices such as Brampton Medical Practice are required to carry out regular clinical audits in areas other than the QOF. The practice's performance in this area would have been verified by the body responsible for overseeing GP education. GPs are also expected to complete at least two clinical audits as part of their annual appraisal arrangements. We were able to confirm that the GP partners (and the GP trainees they supported) had complied with this expectation.

Staff at all levels within the practice were involved in supporting clinical audit activity. For example, we saw that clinical audits had been completed on: polypharmacy (where patients have been prescribed at least four or five medicines); rheumatoid arthritis and the prescribing of steroids. A recent clinical meeting had included items where two GPs had provided information about, and updates on, the clinical audits they had completed or were

# Are services effective?

## (for example, treatment is effective)

carrying out**. (**However, the practice staff we spoke to were unable to provide us with access to examples of full cycle clinical audits, although we were assured these were in place.

The practice used the information it collected for the QOF, and information about its performance against national screening programmes, to monitor outcomes for patients. Information from these data sources showed the practice provided good clinical care. For example: 91.2% of patients with cancer, diagnosed within the previous 15 months, had had a review recorded within three months of the practice receiving confirmation of the test results; 95.3% of patients with chronic obstructive airways disease had had a review in the preceding 12 months, which included an assessment of breathlessness using a recognised tool. These percentages meant the practice had exceeded the standard 80% minimum. The information we looked at before we carried out the inspection did not identify this practice as an outlier for any QOF (or other national) clinical targets.

### Effective staffing

There was a good skill mix within the clinical team. Members of the practice team had developed interests and acted as lead clinicians in these areas. For example, three GPs had been appointed as GP trainers. Another GP had taken on lead responsibilities for overseeing the day-to-day management of the dispensing service. There was a designated safeguarding GP lead. Clinicians at the practice had also completed additional training to help develop their skills and competencies. The practice had two GPs who had trained as GPs with Special Interest (GPwSI), and carried out minor operations and vasectomies. The GP partners carrying out minor operations had received appropriate training. Another GP had completed a diploma in dermatology which we were told had already resulted in a reduction of dermatology referrals to secondary (hospital) care. Practice nurses had completed a range of training to help them meet the diverse needs of patients and the practice manager had completed recognised training in practice management.

We confirmed the GPs partners were up-to-date with their annual, continuing professional development requirements. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). All other staff had received an annual appraisal. However, we did identify that some staff appraisals were overdue.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. The practice received written communications from local hospitals, the out-of-hours provider and the 111 service, both electronically and by post. Staff we spoke to were clear about their responsibilities for reading and actioning any issues arising from communications with other care providers. They understood their roles and how the practice's systems worked.

The practice held regular multi-disciplinary meetings to discuss patients with complex needs, for example, those with end of life care, respiratory and diabetic care needs. These meetings were attended by practice nursing staff as well as local healthcare professionals such as health visitors. Minutes were kept of each meeting and we were told patients' records were updated following these. Clinicians also attended, where appropriate, 'Team Around the Family' meetings organised by the local social services department. (GPs are invited to these meetings so they can contribute to the development and review of support plans for at risk children.)

A member of the practice team attended meetings of the Carlisle Locality Executive which is a sub-group of the local Clinical Commissioning Group (CCG.) This enabled the practice to influence the development of healthcare services within the Carlisle area. We were told Brampton Medical Practice was also one of 12 GP practices involved in the development of the Carlisle Care Home Team. (This team will identify the potential healthcare needs of patients living in care homes and work with other professionals to identify how their needs might be met.)

### Information Sharing

The practice had systems in place to provide staff with the information they needed to carry out their roles and responsibilities. An electronic patient record was used by all staff 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.

# 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 out-of-hours provider. This enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals using the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

The practice had already taken steps to provide patients with access to specific areas of their medical records, i.e. medicines, allergies and adverse reactions, as required under the terms of the 2014/15 GP contract on or before 01 April 2015. Information about how patients could do this was available on the practice website.

### Consent to care and treatment

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 2014 National GP Patient Survey, 76% said the GP they visited had been 'good' at involving them in decisions about their care. Of the patients who responded to the practice's own 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 working at the practice.

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in complying with it. The GP partners we spoke with demonstrated a clear understanding of consent and capacity issues and the Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment). They were able to clearly explain when consent was necessary and how it would be obtained and recorded.

The practice had a consent policy which provided clinical staff with guidance about how to obtain patients' consent to care and treatment, and what to do in the event a patient lacked the capacity to make an informed decision. This policy also highlighted how patients' consent should be recorded in their medical notes, and it detailed what type of consent was required for specific interventions.

The practice kept a register of patients who had learning disabilities. Staff said these patients, and their supporters, were actively involved in the assessment of their needs and that their views were recorded in their medical records. A practice nurse told us these patients were also supported to be involved in planning their care and treatment.

### Health Promotion & Prevention

It was practice policy to offer all new patients a health check with a practice nurse. New patients were able to download a pre-registration form and a medical questionnaire from the practice website which, once completed, they could submit electronically, post or hand into the reception team. Practice nurses carried out assessments of new patients that covered a range of areas, including past medical history and on-going medical problems. The practice offered NHS Health Checks to all patients aged between 40 and 75 years of age. NHS Health Checks had been offered to 1200 patients in 2013/14, and 55% of these patients had attended their healthcare check. (This NHS programme aims to keep patients healthier for longer.)

The practice was good at identifying patients who needed additional support and were pro-active in offering this. For example, there was a register of all patients with dementia. Nationally reported data for 2013/14 showed that: 87.5% of patients with dementia had received a range of specified tests six months before, or after being placed on the practice's register; 71.9% of patients on the dementia register had had their care reviewed in a face-to-face interview in the preceding 12 months. (The latter was slightly below the regional CCG and England averages but there were appropriate reasons for the decisions made to exclude some of the patients on the register.)

Steps had been taken to identify the smoking status of patients over the age of 16 who came into contact with the practice. Nationally reported data for 2013/14 showed the practice supported patients to stop smoking using a strategy that included the provision of suitable information and appropriate therapy. For example, the data showed that the medical records of 86.6% of patients aged 15 and over contained a record of their smoking status in the preceding 24 months. Identifying patients who smoke helps clinicians to offer opportunistic as well as routine targeted care and treatment.

Nationally reported data for 2013/14 showed the practice had protocols that were in line with national guidance, covering such areas as the management of cervical

# Are services effective?

## (for example, treatment is effective)

screening. The practice also had a system in place for informing women of the results of cervical screening tests. Of those female patients who were aged between 25 and 64, 83.2% had received a cervical screening test in the preceding five years. The practice's performance for cervical smear uptake during 2013/14 was 78%. This was better than other practices in the same CCG area.

Younger patients were able to access a range of services aimed at helping them to improve their own sexual health and wellbeing. Chlamydia screening services were provided and patients were able to access free condoms through the Blue Card Scheme. The practice provided a full contraceptive service, including implants and emergency contraception. Patients registered with other practices were also able to access this service.

The practice offered a full range of travel and flu vaccinations. The practice website contained useful information on travel vaccination requirements. Patients were also invited to complete an on-line questionnaire to help practice staff give them the best possible advice. The website also contained a link to a useful booklet about travelling safe in Europe.

Nationally reported data for 2013/14 showed the practice offered child development checks at intervals that were consistent with national guidelines. The practice offered routine immunisations for babies and children under five, during clinic appointments. A robust system was in place for calling up babies and children for childhood immunisations which had resulted in a 98% take up rate. The percentage of patients in the influenza at risk clinical groups, who had received a seasonal influenza vaccination, was in line with other practices in the local CCG area.

We did not see any evidence during the inspection of how children and young people were treated by staff. However, patients we spoke to did not make us aware of any concerns about how staff looked after children and young people.

# Are services caring?

## Our findings

**Respect, Dignity, Compassion & Empathy**

We reviewed the most recent data available for the practice regarding levels of patient satisfaction. This included information from the 2014 National GP Patient Survey and a survey carried out by the practice in 2014. The evidence from all these sources showed the majority of patients were satisfied with how they were treated and the quality of the care and treatment they received.

Patients were treated with kindness, dignity and respect, and their privacy was promoted. 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 2014 National GP Patient Survey, 98% said they found receptionists at the practice 'helpful'. A similar high level of satisfaction was found when respondents to the practice's own survey were asked about the reception team. Out of the respondents who participated, the majority said the reception team was 'helpful', and 98.5% said staff were 'polite' and 'courteous'.

Data from the 2014 National GP Patient Survey showed the practice was rated above the local Clinical Commissioning Group (CCG) average in most of the areas covered. For example, of the patients who responded: 91% said the last GP they saw, or spoke to, was good at giving them enough time (this was above the local CCG average); 80% said the last nurse they saw, or spoke to, was good at listening to them; 84% said the last GP they saw, or spoke to, was good at treating them with care and concern, and 79% said the same in respect of the last nurse they saw or spoke to.

All consultations and treatments were carried out in the privacy of a consulting or treatment room. There were disposable curtains in these rooms to enable patients' privacy and dignity to be maintained during examinations and treatments. Consultation and treatment room doors were kept closed when the rooms were in use so, conversations could not be overheard. Data from the 2014 National GP Patient Survey showed that 71% of patients were satisfied with the level of privacy when speaking to receptionists. This was above the average for the local CCG area. None of the patients we spoke with raised any concerns about practice staff failing to respect their right to privacy. These patients told us the practice offered a good service and staff were helpful and caring. They said staff treated them with dignity and respect and that overall they were satisfied with the care provided by the practice. We did not receive any completed CQC comment cards.

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients were positive about their involvement in planning and making decisions about their care and treatment, and generally rated the practice well in these areas. For example, data from the 2014 National GP Patient Survey showed: 76% of respondents said their GP involved them in decisions about their care; 82% felt the GP was good at explaining treatment and results. Both of these were below the local CCG average when compared to other practices. However, none of the patients we spoke to raised any concerns about their involvement in decisions about their care and treatment.

Staff told us translation services were available for patients who did not have English as a first language. The practice manager said staff would arrange for an interpreter to be used where this would help patients to understand the care and treatment options open to them. The practice website also contained a Google widget which enabled patients to translate web pages into the language of their choice.

**Patient/carer support to cope emotionally with care and treatment**

Patients were provided with the support they needed to cope emotionally with their care and treatment. Of the patients who responded to the practice's own survey, 92.8% 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.

We observed patients in the reception area being treated with kindness and compassion by staff. None of the patients we spoke with raised any concerns about the support they received to cope emotionally with their care and treatment.

Notices and leaflets on display in the waiting room sign-posted patients to a number of relevant support groups and organisations, such as the Alzheimer's Society. The practice website included information for carers such

# Are services caring?

as how to access advice about promoting carer health and wellbeing. For example, a link was provided to a NHS Choices carers support group video. The practice's computer system alerted clinicians if a patient was also a carer, so this could be taken into consideration when clinical staff assessed their needs for care and treatment.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

Systems were in place to address patients' needs and the practice was responsive to them. The practice had used a risk assessment tool to profile patients according to the risks associated with their conditions. This had enabled staff to identify patients at risk of, for example, an unplanned admission into hospital.

The practice had an active Patient Participation Group (PPG) group. PPG members contributed either by attending planned meetings in person or by commenting via email. We saw evidence confirming the practice had sent targeted invitations to patients who were under-represented in the PPG, either by age or ethnicity. We could see some progress had been made, however, the practice manager acknowledged further work was needed to increase representation on the PPG so that it better reflected the practice's population profile. The practice web site also included information about how patients could express an interest in joining the PPG.

PPG meetings took place on a regular basis with the most recent meetings taking place in March 2014 and November 2013. The minutes of the last PPG meeting showed that attendees had been given the opportunity to express their views on results of the latest patient survey carried out by the practice. 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 had planned for, and made arrangements to deliver, care and treatment to meet the needs of older patients and those with long-term conditions. The practice had a register of 270 patients who they had identified as being at risk of an unplanned admission into hospital. The practice had written to each of these patients to make them aware they were on the register and to invite them to attend for an appointment to review their care and support needs. The practice had also written to 1651 patients, aged 75 years and over, informing them which GP partner would act as their named doctor.

A proactive nurse-led annual review system was in place for patients with dementia. This enabled practice nursing staff to assess patients' health and wellbeing, and arrange for any unmet needs to be addressed. The practice IT system alerted clinical staff when an at-risk patient might benefit from their GP carrying out dementia screening. All staff had just completed Dementia Friends awareness training to help improve the care and treatment they provided to patients with dementia.

The practice nursing team were mainly responsible for the delivery of chronic disease management. The practice offered patients with long-term conditions such as diabetes, coronary heart disease and rheumatoid arthritis, access to appointments of varying lengths depending on the reason for the visit. The practice operated a system which recalled these 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 a survey carried out by the practice in 2014 said they felt staff provided good advice which helped them to manage their health condition. The patients we spoke with provided us with similar feedback.

The practice had made arrangements which helped to remove potential barriers to vulnerable patients accessing their services. A small group of travellers were registered with the practice. The practice was aware of the needs of this group of patients. A system was in place to follow up non-attendance, and the practice nursing team was notified of any concerns. Patients were reminded of appointments via the mobile text service the practice used. Systems were also in place which helped ensure patients with learning disabilities received an annual healthcare check. Nationally reported data for 2013/14 showed patients with Down's Syndrome had received a recommended test. The performance of the practice in relation to this was above both the local Clinical Commissioning Group (CCG) and England averages.

Nationally reported data for 2013/14 confirmed the practice had a register of all patients in need of palliative care; and that multi-disciplinary team (MDT) meetings took place every three months to discuss and review the needs of each patient on the register. In practice, we found monthly palliative care meetings usually took place. Each palliative care patient had been given details of how to contact other relevant healthcare professionals. Each patient had a care plan which could be accessed by other healthcare professionals.

# Are services responsive to people's needs?

## (for example, to feedback?)

The practice had planned its services to meet the needs of the working age population, including those that had recently retired. Of those respondents to the 2014 National GP Patient Survey of the practice: 88% said they were satisfied with the practice's opening times, and 91% said their experience of making an appointment was 'good'. Patients' responses to both questions were above the local CCG average.

The practice provided an extended hours service every Saturday morning to facilitate better access to appointments for working patients. The practice website provided working age patients with information about how to book appointments and order repeat prescriptions. Patients had access to an on-line library which contained helpful advice and information about how to cope with common long-term conditions.

The practice had identified those patients who were also carers. This was flagged on the computer system to alert clinicians so it could be taken into account when assessing these patients' care and treatment needs. Information about how to access carer groups and other support and advice was available in the reception area.

The practice worked collaboratively with other agencies and regularly shared patient information to ensure good, timely communication of changes in care and treatment. The practice provided the out-of-hours and emergency care services with access to care plan information about patients who had palliative care or complex health needs.

The practice received details of any contact the out-of-hours service had had with its patients electronically the following morning. We were told any information received was checked by a designated GP so that appropriate action could be undertaken by the right member of staff.

Turnover of staff at the practice was low. We were told some staff had worked at the practice for a considerable number of years. The practice manager said the staff group was settled, and up to full capacity with the exception of one GP vacancy.

**Tackle inequity and promote equality**

The majority of patients did not fall into any of the marginalised groups that might be expected to be at risk of experiencing poor access to health care, for example, homeless people and Gypsies and Travellers. We were told the practice took whatever action it could to meet the needs of patients who fell within this population group. For example, homeless people wishing to register with the practice would be allowed to do so even though they did not have a fixed address. The practice had a small number of patients with learning disabilities. Suitable arrangements had been made to meet their needs.

Reasonable adjustments had been made which helped patients with disabilities and patients whose first language was not English to access the practice. The practice premises had been adapted to meet the needs of patients with disabilities. For example, GP and nurse consultation rooms and practice reception areas were located on the ground floor. A loop system had been fitted to assist patients who were hard of hearing. A disabled toilet was available on the ground floor. However, the toilet did not have an emergency buzzer to alert staff in the event of an emergency. The waiting area was large enough to accommodate patients with wheelchairs and prams, and enabled easy access to the treatment and consultation rooms. The practice had a very small number of patients whose first language was not English. Staff had access to a telephone translation service but the practice manager said this was seldom used.

**Access to the service**

Appointments were available from 08:00am to 6:30pm each weekday at the main practice site in Brampton. Extended hours were also provided between 08:00am and 10:45am each Saturday. Information about opening hours at the Wethral and Corby Hill branches was clearly indicated on the practice website. Extended hours were not provided at the branch surgeries. Patients were able to book appointments by telephone, by visiting the practice or on-line via the practice web site.

Information about how to make appointments was available on the practice website. The practice offered patients different ways of accessing appointments. For example, patients were able to do this by telephone, by visiting the practice or by accessing the on-line appointments system. Patients were able to book appointments up to three weeks in advance at any time of the day. Longer appointments were available on request. Each doctor had a number of appointments available each day so that patients could access same day care and treatment when necessary. The practice also had a daily duty doctor who responded to all requests for urgent care

# Are services responsive to people's needs?

## (for example, to feedback?)

once the 'bookable on the day' appointments had been used up. This included responding to any requests for home visits. Advice on the criteria for requesting a home visit was available on the practice website.

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.) GP partners were involved in this process when demand for appointments was high. The practice had installed a patient self check-in screen since the last inspection to help reduce the pressure on the reception team.

Patients were satisfied with the practice's appointments system. Of the patients who participated in the National GP Patient Survey: 65% of those who had a preferred GP, usually got to see or speak to that GP; 85% said they found it 'easy' to get through on the telephone to someone at the practice; 88% said the practice opened at times that were convenient to them; 74% said they usually waited 15 minutes or less after their appointment time to be seen, and 68% said they didn't normally have to wait too long to be seen. Patients' responses to all of these questions were above the local CCG average. None of the patients we spoke with expressed concerns about access to appointments.

The practice's website and leaflet provided patients with information about how to access out-of-hours care and treatment. When the practice was closed there was an answerphone message giving the relevant telephone numbers patients should ring. Of the patients who participated in the National GP Patient Survey: 96% said it was easy to telephone the practice; 68% felt they received out-of-hours care quickly and 74% described their out-of-hours experience as good.

**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 the contractual obligations for GPs in England. Practice staff were able to access the complaints policy via the practice intranet. The practice manager was the designated responsible person for handling all complaints.

Information was available to help patients understand the complaints process. Information on the practice website encouraged patients to contact the practice if they had a complaint. Information about how to complain had been included in the practice leaflet which patients were easily able to access. All of the patients we spoke with said they had never had to make a complaint but would feel comfortable in doing so. A suggestions box was available in the waiting area providing patients with an opportunity to raise concerns anonymously.

During the inspection we looked at complaints the practice had received since our last visit. We saw these had been dealt with in a timely manner, and where appropriate, an apology had been issued.

# Are services well-led?

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

## Our findings

**Vision and Strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Staff were committed to achieving the best possible outcomes for patients and this was demonstrated by the practice's (Quality Outcomes Framework (QOF) performance. The practice's statement of purpose provided a clear outline of what the practice was committed to achieving and how it would deliver its overall aims and objectives. The statement included the following aims: 'To provide a quality, safe service for all our patients whenever they need our support; To focus on the prevention of disease by promoting health and wellbeing and offering care and advice to all our patients; To work in partnership with our patients, their families and carers towards a positive experience and understanding, involving them in decisions about their treatment and care, and choice in who, where and when their treatment is provided.' Discussions about the practice's future development took place at GP partner and clinical practice meetings, and at occasional evening meetings which focussed on planning the strategy for achieving its vision. The 2014 Protected Learning Team (PLT) plan provided evidence that the overall performance of the practice was regularly reviewed.

**Governance Arrangements**

The practice had a range of policies and procedures in place concerning its activities and the services it provided to patients. Staff were able to access these via the practice intranet. We saw evidence that policies and procedures were reviewed.

The practice used data from the QOF to measure its performance. In 2013/14, the QOF measured achievement against 121 indicators. When we checked the most recent information available to us, we saw the practice had achieved 95.7% of the maximum points possible. This confirmed the practice had delivered care and treatment in line with expected national standards, and its overall achievement was above both the local Clinical Commissioning Group (CCG) and England averages.

QOF data was discussed at various internal practice meetings, and during peer review sessions. This helped to ensure key staff were aware of how the practice was performing, and what actions needed to be taken to ensure it met its QOF targets. In addition to this, the practice manager regularly reviewed the QOF data in order to identify how outcomes for patients could be maintained or improved. The 2014 PLT plan provided evidence that QOF performance was considered at various intervals throughout the year. QOF data confirmed the practice participated in an external peer review with other practices in the same CCG group, in order to compare data and agree areas for improvement.

A range of clinical audits had been completed. All staff were involved in and contributed to the clinical audit process and we saw learning from these was shared at practice clinical meetings.

The practice had suitable arrangements in place for identifying, recording and managing risks. For example, a health and safety assessment had been completed. A contingency plan was in place to help ensure patients continued to receive a service in the event of an emergency.

**Leadership, openness and transparency**

The practice had a clear leadership structure which was known to staff. There were clear lines of accountability with specific tasks being delegated to, and undertaken by, designated staff. For example, GP partners acted as clinical leads depending on their clinical interests. The staff we spoke to were clear about their own roles and responsibilities. The reception staff told us they felt well supported, knew who to go to with any concerns and had access to a lead GP who was responsible for dealing with any reception issues. They said the practice manager's door was always open.

Regular clinical and partner meetings took place where operational issues and patients' needs were discussed. Departmental meetings led by the designated practice lead also took place during PLT sessions.

A range of human resource policies and procedures were in place, and these included harassment and bullying at work. Staff we spoke with said they were able to access all the practice policies and procedures via their desktop computers.

**Practice seeks and acts on feedback from users, public and staff**

An external organisation had been commissioned to carry out a survey in 2014 which sought patients' opinions about

# Are services well-led?

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

how well Brampton Medical Practice cared for them. The survey covered such areas as satisfaction with the performance of the GPs and nurses and whether opening times were convenient. The majority of patients who responded to the survey described their experience of using the practice as 'good'. Over 97% of respondents said they would recommend the practice to someone who had just moved into the area.

The practice had an active Patient Participation Group (PPG) group. Minutes of the PPG meetings had been uploaded onto the website so that patients could find out about the work the group undertook. The practice manager had produced an annual report for 2013/14 which identified the current areas of priority for the PPG and included an action plan to achieve agreed objectives.

Regular meetings and protected learning sessions provided staff with opportunities to comment on, and feel involved in the running of the practice. The staff we spoke to felt valued and said they felt they were an important part of the practice team. Staff also said team work was good.

**Management lead through learning & improvement**

Staff told us the practice supported them to maintain their clinical and professional development through training and mentoring. The practice nurse we spoke to said they had received the training they needed to carry out their roles and responsibilities. The practice had completed reviews of significant events and other incidents. It had shared the outcomes with staff via meetings to help ensure the practice improved outcomes for patients. A PLT plan was in place for the current year and this set out what training sessions were planned. We were told speakers were invited to attend clinical meetings to provide staff with updates and information about developments in the community.

The practice had achieved accreditation as a training practice. To do this the practice had to meet higher than usual standards of performance in areas such as patient medical records and providing a safe working environment.

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<br><br>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. |