Dr J Barry-Braunthal & Partners

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced, comprehensive inspection at Lodgeside Surgery on the 11 December 2014. Overall the practice was rated as GOOD. Specifically, we found the practice to be outstanding for providing responsive services. It was good for providing caring, safe, effective, well led services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Easy read information was provided to help patients with learning disability understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Representative Group (PRG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- Patients had access to a range of appointments such as same day appointments and booking in advance.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.

We saw several areas of OUTSTANDING practice including:

Summary of findings

- Early Home Visits scheme for older, frail and vulnerable patients.
- Same day patient registration with the practice to enable patients with alcohol and drug misuse to access to accommodation based alcohol and drug services.
- Homeless asylum seekers were able to register and see a GP within 24 Hours and have immediate access to services.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. The practice used a range of information to identify risks and improve quality regarding patient safety. There were systems for reporting, recording and monitoring significant events. There were processes which recognised and supported patients who were at risk of abuse. Staff were aware of their roles and responsibilities with regard to protecting patients from abuse or the risk of abuse. There was written guidance for the recruitment and selection of new staff. The practice had a system to enable sufficient staff numbers to meet service requirements. Patients were cared for in a safe environment. The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies. Equipment was regularly serviced and maintained. Patients were protected from the risks of unsafe medicine management procedures. Repeat prescribing procedures ensured patients had regular medicines reviews to monitor medicines were appropriately prescribed. Patients were cared for in an environment which was clean and reflected appropriate infection control practices.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' care and treatment was delivered in line with recognised best practice standards and guidelines. The practice met nationally recognised quality standards for improving patient care and maintaining quality and compared favourably with other practices in the area. The practice had a system in place for completing clinical audit cycles to evidence treatment was in line with recognised standards. Patient care was improved by the regular monitoring of treatment. The practice worked with other health care providers to enable prompt treatment, reduce hospital admissions and enable patients to be treated at home. Patients' rights were protected with regard to the consent process. Staff were confident in their understanding of their legal and ethical responsibilities for gaining informed consent prior to treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were generally positive about their care and treatment. We observed staff were supportive in their interactions with their patients. Patient privacy and confidentiality was not easily maintained in the practice reception and waiting area. The practice was aware of the importance of maintaining confidentiality and privacy and could

Summary of findings

demonstrate they had begun to address the issues. Patients told us they were involved in treatment choices. Staff gave examples of how care planning enabled patients with long term conditions to be involved in their care. Patients said they were treated with compassion, dignity and respect. We saw there was health information available for patients on the website and in the practice. Information specific to patients with learning disabilities regarding health screening was also available.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. Overall the practice enabled patients to access the care they needed. Patients were able to speak or see a GP if they required an urgent appointment. Patients could also sit and wait in the surgery without an appointment if they needed to see a GP urgently. Appointments could be booked in advance. The practice had a system to triage all visits before 10am and prioritise frail/vulnerable patients for an early Home visit to facilitate any hospital admissions within 'working hours' to avoid evening admissions. The practice supported three care homes with weekly visits by a named GP. GPs worked closely with other agencies to enable homeless and vulnerable patients to register with the practice quickly to enable patients to access the services they needed. The practice had arrangements in place to support patients with disabilities. There was a loop system for patients with hearing difficulties. The layout of the building enabled patients with mobility needs to gain access without assistance. The practice had a comprehensive complaints system. The practice responded to patients' concerns and suggestions to improve the primary care services provided.

Are services well-led?

Good 

The practice is rated as good for being well-led. GP partners were proactive in their involvement in local health matters through their involvement with the Clinical Commissioning group and early adoption of initiatives to support patients. Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters. Staff told us they worked well as a team and were supported to undertake their role. GPs and nurses were encouraged to update and develop their clinical knowledge and skills. Each member of staff had a comprehensive annual performance review and personal development plan.

Summary of findings

The six population groups and what we found

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

Older people

Good

The provider was rated as outstanding for responsive overall and this includes this population group. However, the provider was rated good for safety, well-led, caring and effective which led to these ratings applying to everyone using the practice, including this population group. The practice supported older patients by enabling access to services without patients having to attend the practice for example, ordering repeat prescriptions via the practice website. The practice had a system to triage all visits before 10am and prioritise frail/vulnerable patients for an early home visit to facilitate any hospital admissions within 'working hours' and to avoid evening admissions. Patients had a named GP. Nationally reported data showed the practice had positive outcomes for conditions commonly found amongst older patients and had the highest uptake of flu immunisation in the locality. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services for example, in dementia and end of life care. Frail and vulnerable patients had care plans to enable prompt treatment, reduce hospital admissions and enable patients to be treated at home.

People with long term conditions

Good

The provider was rated as outstanding for responsive overall and this includes this population group. However, the provider was rated good for safety, well-led, caring and effective which led to these ratings applying to everyone using the practice, including this population group. Emergency processes were in place and referrals made for patients who had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a structured annual review to check their health and medication needs were being met. For those patients' with the most complex needs the named GP worked with relevant health and care professionals to develop patient care plans and a multidisciplinary package of care.

Families, children and young people

Good

The provider was rated as outstanding for responsive overall and this includes this population group. However, the provider was rated good for safety, well-led, caring and effective which led to these ratings apply to everyone using the practice, including this population group. Systems were in place for identifying and following-up children who were at risk. For example, the GP met regularly with health visitors to review children and their families at

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risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. GPs offered a range of contraceptive services for patients and chlamydia (a sexually transmitted infection) screening kits for under 25's.

Working age people (including those recently retired and students)

Good

The provider was rated as outstanding for responsive overall and this includes this population group. However, the provider was rated good for safety, well-led, caring and effective which led to these ratings applying to everyone using the practice, including this population group. The practice supported the working age population and those recently retired by providing screening for common medical conditions. They offered a flexible appointment system including earlier morning, later evening and Saturday morning appointments. Patients were able access to access health information and practice services via the practice website. Patients were able to monitor their blood pressure by using the self-monitoring machine in the practice.

People whose circumstances may make them vulnerable

Good

The provider was rated as outstanding for responsive overall and this includes this population group. However, the provider was rated good for safety, well-led, caring and effective which led to these ratings apply to everyone using the practice, including this population group. The practice held a register of patients with learning disabilities. The practice told us they were highest performing practice in the locality for undertaking health checks for patients with learning disability. Longer appointments for patients with learning disabilities were arranged in recognition of the time needed to involve patients in their care and treatment. There was a named GP who undertook weekly visits to two care homes one supporting patients with learning disabilities and the other caring for patients with head injury and neurological conditions. The practice regularly worked with multi-disciplinary teams and other agencies in the case management of vulnerable patients. For example, the practice had a system to enable homeless patients and patients with drug and alcohol support needs to register quickly to enable them to access the treatment and support they needed. The practice was working with the Red Cross to enhance support and assist in the signposting of patients to support organisations.

Summary of findings

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact within the practice.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as outstanding for responsive overall and this includes this population group. However, the provider was rated good for safety, well-led, caring and effective which led to these ratings apply to everyone using the practice, including this population group. The practice had started writing care plans for patients who experienced poor mental health. Quality data from the Quality and Outcomes Framework 2013/2014 (QOF is a national performance measurement tool) demonstrated the practice compared favourably with other practices in the assessment of depression. The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions. We saw the practice website included links to other information and support services. All patients on the dementia register had completed reviews. We noted nursing staff were aware of the importance of recognising patients in the early stages of dementia and undertook opportunistic, simple tests to aid detection.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with seven patients attending the practice. We looked at eight patient comment cards, the practice survey (2013) and the GP National Patient Survey 2013/2014 and 11 comments on the NHS Choices website.

Patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients were overall satisfied with the care and treatment received. They described all staff as professional, compassionate and supportive. This was supported by feedback from the GP National Patient Survey 2014 which indicated 89% of the practice respondents said the last GP they saw treated them with care and concern. 89% of respondents described their experience of the practice as fairly good or very good. Overall patients we spoke with felt their privacy and dignity were respected. The practice had made changes to the practice in response to patients' comments about the level of confidentiality in the reception area.

87% of patients in the GP National Patient Survey described their experience of making an appointment as good or fairly good. All of the patient feedback told us patients were able to see or speak to a GP if their appointment was urgent on the day of need. Patients requesting to see the GP of their choice had a longer wait of up to two weeks. However, comments on the NHS choices website indicated two of the 11 respondents found it difficult to get an appropriate appointment. The practice response was that more on the day appointments were being released to meet patient demand.

Patients told us they appreciated they were able to book appointments up to eight weeks in advance which helped with planning work commitments. Two patients we spoke with commented on the wait to be seen when they had an appointment, however they appreciated the GPs gave them the time they needed during their consultation.

Patients we spoke with were not aware of the complaint process even though there was information available in the practice. They expressed confidence in the practice to address concerns when they were raised.

Patients' feedback told us patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. This was supported by feedback from the GP National Patient Survey 2013/14 which indicated 90% of patients said the last GP they saw was good at involving them in decisions and 85% said the last GP they saw was good at explaining tests and treatments.

Patients told us they were satisfied with the cleanliness of the practice.

Outstanding practice

We saw several areas of OUTSTANDING practice including:

- Early Home Visits scheme for older, frail and vulnerable patients.
- Same day patient registration with the practice to enable patients with alcohol and drug misuse to access accommodation based alcohol and drug services.
- Homeless asylum seekers were able to register and see a GP within 24 Hours and have immediate access to services.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor.

Background to Dr J Barry-Braunthal & Partners

As part of the inspection we visited the practice at 22, Lodgeside Avenue, Kingswood, Bristol, BS15 1WW.

Lodgeside Surgery provides primary care services to patients resident in the town of Kingswood on the east side of Bristol. The practice is purpose built with most patient services located on the ground floor of the building with patient lift to access the first floor. The practice has an expanding patient population of approximately 9,550 of which the highest proportion are of working age. The practice trains GP's, medical students and student nurses.

The practice has four female and one male GP partners. They employ three GPs, three nursing staff, one phlebotomist, a practice manager, and reception/ administration staff. Most staff work part-time.

The CQC intelligent monitoring placed the practice in band six. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice is open six days of the week. Tuesdays, Thursdays and Friday it is open 8.am - 6.30pm. Mondays 8.00am -7.30pm and Wednesdays 7.30am – 6.30 pm. The practice is open on Saturday mornings from 9am -11am for pre-booked appointments.

The practice has opted out of the Out of Hours primary care provision. This is provided by another provider BRISDOC.

Why we carried out this inspection

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

How we carried out this inspection

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

Detailed findings

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

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health (including patients with dementia)

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the Bristol Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 11 December 2014. During the inspection we spoke with four GPs, the practice manager, four nursing staff and administration staff. We spoke with seven patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the importance of sharing with staff when a patient had died to avoid misunderstanding and unnecessary distress for relatives.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had a dedicated GP lead in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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

There were notices advising patients about requesting a chaperone in all patient areas.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

We were told there was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

Are services safe?

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The repeat prescribing procedure protected patients from risk. There were systems in place to identify when patients required a medicines or health review before further prescriptions were issued. Drug interactions and drug alerts were clearly identified on the practice electronic system. Newly registered patients taking regular medicines were seen by a GP for a health check.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. We saw evidence that the lead carried out infection control audits annually and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Equipment maintenance logs and other records that demonstrated equipment was tested and maintained regularly. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice had a health and safety policy and all staff attended health and safety training.

Are services safe?

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We were told that any risks were discussed at GP partners' meetings and within team meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Nurses and GP's undertook training annually and administrative staff every three years. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. Staff gave an example of how they successfully managed a medical emergency concerning a patient who had an anaphylactic event (severe allergic reaction) and that practice had learned from this appropriately. Further guidance was sought from Public Health England to ensure they had up to date information when giving immunisations.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. We noted that the fire alarm point log required up dating however, all other fire records were up to date.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from other research reports. For example, reference to guidance to manage sinusitis (an inflammatory condition of the sinuses). The use of guidance prompted clinical audit and reviews of clinical guidelines. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the use of care pathways and care plans for patients with long term conditions such as heart and respiratory disease.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We looked at data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used a risk stratification tool to identify 2% of the most vulnerable patients on the practice list. We saw that all these patients had a personalised care plan to assist in their support and treatment to avoid admission to hospital.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with a suspected cancer.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us 24 audits had been completed in 2014. Some of these were part of a practice annual audit programme for example, an annual review of patient consent and infection prevalence following joint injections. Others were linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of medicines used to manage nausea and vomiting in response to a safety alert. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

Following each clinical audit, changes to treatment or care were made where needed and some audits had been repeated to ensure outcomes for patients had improved. For example, following a review of referrals to ear nose and throat (ENT) hospital services a clinical audit was undertaken. The aim of the audit was to evaluate whether patients were appropriately managed and referred in line with best practice guidance. Results from the first audit demonstrated that 50% of the small sample of patients meeting audit criteria could have been managed more effectively prior to hospital referral. The information was shared with GPs and a clinical guideline was produced for GP reference and a patient information leaflet developed. A

second clinical audit was completed six months later which demonstrated that more patients had been managed appropriately and the quality of referrals to hospital ENT services had improved.

We looked at another audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date and had attended mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with number having additional training and qualifications in sexual and reproductive medicine, dermatology (skin) and dementia. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example insulin initiation (starting patients on insulin from tablets or diet management). As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for an enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) to support frail patients to avoid admission to hospital. The GPs worked with the multidisciplinary team to develop and review patient care plans to meet the changing needs of these patients. There was a process in place to follow up patients discharged from hospital. We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The monthly multidisciplinary team meetings also provided an opportunity to discuss the needs of other patients with complex needs, for example those with end of life care needs or children on the 'at risk register'. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented directly onto patients' notes. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. In addition the practice worked with dementia services and met every two months to review the care and support of patients diagnosed with dementia.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, for example, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key

Are services effective?

(for example, treatment is effective)

clinical information for healthcare staff treating patients in an emergency or out of normal hours). There was comprehensive information for patients about this on the practice website.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw that an audit (2014) had been carried out to assess the timeliness of reviewing patients discharge summaries from secondary care. The results demonstrated the practice managed discharge information promptly.

Consent to care and treatment

We found that GPs and nurses applied the principles of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 to their practice area.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). We noted all patients on the dementia register had been reviewed in 2014. Patient consent was required for referral to the learning disability service and this was documented in their patient record.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. All new patients had their blood pressure recorded, urine tested, height and weight measured, smoking status and alcohol consumption documented. Any health concerns from this were followed up by a member of Nursing team or GP.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice had number of ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse and GP.

The practice actively offered smoking cessation clinics to patients. There was evidence these were having some success. A practice audit demonstrated they had an above average quit rate compared to other practices in the area.

The practice's performance for cervical smear uptake was 72.2%, which was comparable to others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. Performance for national mammography and bowel cancer screening was similar to the average for the CCG (67.7% and 55.9% respectively).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a protocol for following up non-attenders by the named practice nurse.

Patients were able to monitor their blood pressure by using the self- monitoring machine in the practice. They also had access to home monitoring blood pressure machines which for some patients meant they avoided an overnight stay in hospital.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP National Patient Survey (2013/2014), a practice survey of 189 patients (2013) The evidence from all these sources showed patients were satisfied with how they were treated. For example, data from the GP National Patient Survey (2013/14) indicated 89 % of respondents rated the practice as good or very good. The GP National Patient Survey identified 89% and 92% of practice respondents said the GP and nurse (respectively) was good at treating them with care and concern. 90% of respondents said the doctors and nurses were good at listening to them.

Patients completed CQC comment cards to tell us what they thought about the practice. We received eight completed cards and they were all positive about the service experienced. Patients said they felt the practice offered a very good service and staff were compassionate, professional, supportive and caring. They said staff treated them with dignity and respect. We also spoke with patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

The practice had responded to patient feedback about threats to privacy and confidentiality in the reception and waiting area. This had resulted in the switchboard being separated from reception so that telephone conversations were not easily overheard. In addition there was a sign to inform patients of the availability of a private room for confidential conversations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions 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 GP National Patient Survey showed 79% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results compared favourably to the CCG average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The nurses we spoke with demonstrated their understanding of how mental health issues impacted on their patients. Examples included factors that prevented them from attending the surgery such as the weather. The nurses adapted to their patients' needs by sensitive scheduling of appointments and allowing plenty of time. We spoke with two patients who confirmed the benefits of the nurses' approach in accessing the care they needed.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice told us they engaged regularly with the CCG and other practices to discuss local needs and service improvements that needed to be prioritised. For example, two of the GPs were elected members on the CCG influencing commissioning of services for their locality. In addition one GP was dementia lead for the CCG and was actively involved in commissioning dementia services. The practice manager was also involved locally to lead the development of a plan to improve the co-ordination and support for hospital discharge of frail elderly patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient representative group (PRG). For example, improving patient access to the phone in the mornings by increasing the number of staff available to respond to calls.

The practice had an expanding patient population of which the highest proportion were of working age. In response to this the practice offered a flexible appointment system opening early and late one day a week and a Saturday morning for patients not able to attend during normal working hours.

Systems were in place for identifying and following-up children who were at risk. For example, the GP met regularly with health visitors to review children and their families at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. GPs offered a range of contraceptive services for

patients and chlamydia (a sexually transmitted disease) screening kits for under 25's.

Patients requiring joint injections could have these undertaken at the practice which avoided a visit to hospital. A recent audit demonstrated 80% of the injections were deemed effective. In addition one GP had undertaken training in the use of a dermatoscope (a microscope to study skin lesions) in order to more accurately assess patient skin lesions.

Tackling inequity and promoting equality

The practice provided equality and diversity training through e-learning. Staff were expected to update every three years. Training records confirmed staff were up to date with their training. The practice had access to online and telephone translation services.

The practice had recognised the needs of different groups in the planning of its services. For example, there was a rapid registration process for patients who were asylum seekers and homeless which enabled immediate access to primary care services. The practice worked closely with a local accommodation based drug and alcohol service where registration was a requirement. Before the patient could access the service. The practice gave an example where they were asked to see a patient at 3pm. The patient was seen and registered with the practice at 5pm on the same day and was then able to access support and accommodation from the drug service.

The practice held a register of patients with learning disabilities. The practice told us they were highest performing practice in the locality for undertaking health checks for patients with learning disability. Quality and Outcomes Framework (QOF 2013/2014) demonstrated the practice was above the Clinical Commissioning Group average.

Longer appointments for patients with learning disabilities were arranged in recognition of the time needed to involve patients in their care and treatment. Patients with learning disabilities had access to easy read copies of health promotion information such as cervical smear screening and breast examination.

Patient services were situated on the ground floor of the building. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Are services responsive to people's needs?

(for example, to feedback?)

The practice was working with the Red Cross to enhance support and assist in the signposting of patients to support organisations.

Practice staff met regularly with members of the multidisciplinary team to support those patients at end of life or with long term conditions. There was a practice protocol in place for nurses to undertake additional diagnostic tests during routine contact with patients such as routine health checks. We were given examples of how older patients who seemed confused or forgetful were sometimes offered a simple diagnostic test for early stage dementia. Based on the GP appraisal of the results they could then work with the patient to determine the appropriate support.

Access to the service

The practice was open six days of the week. Tuesdays, Thursdays and Friday it was open 8.am - 6.30pm. Mondays 8.00am -7.30pm and 7.30am – 6.30pm on Wednesdays. The practice was open on Saturday mornings from 9am -11am for pre-booked appointments. Patient feedback indicated they were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. We were told by the registered manager patients requiring immediate but not emergency (999) could come straight in and they would be seen. In addition if appointments were not available patients could wait in the practice after 5.30pm and they would be seen by a GP. They also said they could see another doctor if there was a wait to see the doctor of their choice. The practice told us patients were offered telephone appointments and could book appointments up to eight weeks in advance.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the practice leaflet and website.

Appointments were available outside of school hours for children and young people. The practice has a system to triage all visits before 10am and prioritise frail/vulnerable patients for an early home visit. This enabled the GPs to facilitate admission to hospital if necessary within 'normal' working hours.

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

Home visits were made to three care homes; one for patients with learning disabilities, another for patients with acquired brain injury and neurological conditions and a care home for older adults. We were told a named GP visited on a specific day each week to review patients care.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. Although patients we spoke with were not aware of the process to follow if they wished to make a complaint they said they felt able to report concerns and had confidence the practice would manage them appropriately. None of the patients we spoke with on the day of the inspection had ever needed to make a complaint about the practice.

The practice reviewed complaints regularly to detect themes or trends. Fifteen complaints were reported in 2014. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care, promote good outcomes for patients and work in partnership with patients. The practice values emphasised a professional, friendly and responsive approach dedicated to providing high quality personalised care to all its patients. Staff we spoke with were aware of the practice values and we saw examples of how these values were reflected in practice. For example, staff were caring and respectful, knowledgeable about their patients' specific needs to enable a high standard of care and treatment.

The practice was proactive in working with other the Clinical Commissioning Group, GPs and other agencies to improve patient services within the locality such as commissioning dementia services.

Governance arrangements

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a nurse with lead responsibilities for infection control and one GP had lead responsibilities for safeguarding.

The practice had policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a range of these policies and procedures and saw staff had confirmed when they had read the policy. The policies and procedures we looked at had been reviewed and were up to date.

The practice held regular practice meetings including governance issues. We looked at minutes from the meetings and found performance, quality and risks had been discussed. Significant event meeting records were consistently completed as a learning resource.

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

The practice had completed a number of clinical audits, for example, a contraceptive coil audit, an audit of joint injections and sinusitis treatment and referral. Most audits had completed a full audit cycle to demonstrate the effectiveness of the changes made.

The practice had a schedule to assess and update practice risk assessments. The schedule included the frequency and date of assessment. We saw these had been completed on time.

Leadership, openness and transparency

Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns. Staff told us they were well informed of practice issues. We saw there were a range of regular meetings for teams. For example, the nursing team met weekly with one of the GPs to discuss clinical and practice issues.

Staff had access to on-going professional development opportunities and regular appraisal.

We saw evidence of changes to practice resulting from learning from incidents and significant events. For example, an update of immunisation information following the successful management of a medical emergency concerning a patient who had an anaphylactic event (severe allergic reaction) reaction following immunisation.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. These were well organised, up to date and reflected

current HR procedures.

Practice seeks and acts on feedback from its patients, the public and staff

The practice gathered feedback from patients through patient surveys, complaints and the patient representation group (PRG). The results and actions agreed from these surveys were available on the practice website. The practice had an active virtual PRG group mostly made up of representatives from a working age group.

We looked at the results of the PRG annual patient surveys (2013) and questions raised by patients to the group. The practice had responded to a range of comments including improving privacy and confidentiality in the reception area by separating the administration area from reception. Minutes from the December 2014 GP and PRG meeting demonstrated the survey results and other patient

Are services well-led?

Good

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

concerns and practice developments were discussed at PRG meetings. The meeting minutes, results and actions agreed from the survey were available on the practice website, newsletter and as a hardcopy on request.

Staff told us they were able to give feedback and discussed any concerns or issues with colleagues and management. Overall staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available for all staff to read as guidance

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated overall management lead through learning and improvement. For

example, audit cycles were completed, action plans were reviewed and communication across the whole staff group took place. Learning took place through the review of significant events and other incidents and shared with staff who did not attend via meeting minutes circulated as an email.

Staff told us and training records confirmed staff were able to remain updated with mandatory training requirements. We saw continuing professional development opportunities were supported. Staff files demonstrated regular appraisals took place which included a personal development plan.

New staff were supported via an induction programme and specific support to orientate and train them for their role.

The practice was a GP training practice for GP registrars specialising in primary medical care. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice.