Dr C R Burr & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bourne Galletly Medical Practice on 2 December 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people who circumstances may make them vulnerable, and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed. Human Resource policies, procedures, files and processes in this regard were of a high standard.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with appointments available the same day. The practice offered a telephone triage service. That service was available for all patients in all population groups
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe. 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

Are services effective?

Good

The practice is rated as good for providing effective services. Staff referred to guidance from NICE (National Institute for Health and Care Excellence) and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and planned. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

The practice had carried out a patient access audit in which they had identified problems with the appointment system. As a result changes were made and over 99% of patients were now seen on the same day.

Summary of findings

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

Are services well-led?

Good

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

The practice had a very large and active patient participation group (PPG) which had been in existence for a number of years. The PPG met every month and additionally held a six monthly away-day and AGM. All those meetings were attended by the Business Partner and a GP Partner. All meetings were minuted and available. The PPG produced in conjunction with a neighbouring practice a booklet for patients that signposted organisations within the local area to assist patients. It also advised patients on when to use A&E and minor injuries units and when not.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. There was a named accountable GP for all patients. There was a designated lead GP for all care homes served by the practice

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The nursing team at the practice had been fully trained in long term condition management, including independent prescribing and insulin initiation.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. All staff within the practice had completed safeguarding of children and vulnerable adult training. The practice also provided an acute illness clinic with qualified prescribing nurses and this was supported by the duty GP

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered a telephone triage service

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. In addition the practice had provided training in how to recognise signs of domestic violence and how to escalate concerns to all staff and had a written protocol, this was in response to an identified need.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 94% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E)

where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia. The practice had same day access for people experiencing poor mental health and named GPs who worked with the patients' CPN (community psychiatric nurse)

The Practice offered an Enhanced Service for Profound Mentally Impaired/Disabled patients (PIMD). This is the sole service for the county and was designed/commissioned as a result of the high quality of care offered to those patients.

Summary of findings

What people who use the service say

We spoke with 6 patients in the reception and waiting areas of the practice including patients from a number of different practice population groups.

The practice was highly praised by all the patients we spoke with and were very happy with the service they received. They told us that the GPs and the nurses were caring, patient, kind and treated them with respect. Patients told us they were much happier with the new access to appointments system that had been put in place.

Patients had completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these.

In the latest national GP patient survey on this practice 254 surveys were sent out and 124 were returned. 89% of respondents said the last GP they saw or spoke to was good at listening to them, 82% of respondents usually wait 15 minutes or less after their appointment time to be seen and 70% of respondents with a preferred GP usually get to see or speak to that GP.

Those results pre-dated a change of appointment system. Since that introduction 99.5% of patients were receiving a same day appointment of which 92% were with a GP of choice at the time of the inspection. These results were all above the CCG average.

Dr C R Burr & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, and a practice manager.

Background to Dr C R Burr & Partners

Bourne Galletly Medical Practice, deliver primary care under a General Medical Services (GMS) contract. As part of the NHS South Lincolnshire Clinical Commissioning Group (CCG), the practice are responsible for a patient group of 10800 in a radius of approximately 5.5 miles from the centre of Bourne.

Nearly 36% of the practice population are over the age of 65 and this is the largest population group but only just with the group under the age of 18 measured at nearly 35% and the working age group at nearly 29%.

Services include access to four male partner GPs, one female partner GP and a salaried GP. There is an all-female nursing team consisting of a one Lead Nurse, four Practice Nurses (four of whom are Independent Nurse Prescribers), two Assistant Practitioners and two Health Care Assistants. The practice is also a Nurse Training Practice and a Research Ready accredited practice. The practice is a training practice and trains doctors to become General Medical Practitioners and are part of the East Midlands Deanery.

The GPs are able to carry out a number of minor surgery procedures. The practice offers a full range of general medical services including maternity, child health, vaccination, contraception, chronic disease management, warfarin and disease modifying anti-rheumatic drug monitoring. Treatment room services include travel vaccination services in addition to the child vaccinations. Leg ulcer management, minor injuries and minor illness advice is also offered by the practice nursing service.

The surgery was also a dispensing practice and there was a full dispensing team led by a dispensary manager and a team of five dispensers.

The administration team was managed by a deputy manager, administration manager and six administrators. The reception team is managed by a reception manager, senior receptionist and six receptionists. The practice is managed by the business partner. This team was highly praised by all the patients we spoke with.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. We carried out the inspection under Section 60 of the Health and Social Care Act as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

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.

Detailed findings

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

• Older people

• People with long-term conditions

• Families, children and young people

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

• People whose circumstances may make them vulnerable

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

Before our inspection we reviewed a range of information we held about the practice and asked other organisations to share what they knew. We asked South Lincolnshire Clinical Commissioning Group (CCG) and the local Healthwatch to tell us what they knew about the practice and the service provided. We reviewed some policies and procedures and other information received from the practice prior to the inspection.

We carried out an announced inspection on 2 December 2014. During our inspection we spoke with all the staff available on the day. This included four of the GP partners, one salaried GP, three practice nurses, the business manager, four administration staff, two members of reception, the lead nurse, one health care assistant (HCA), the dispensary manager and three dispensers. We spoke with six patients who used the service and members of the patient participation group. We reviewed comments from 31 CQC comments cards which had been completed. We observed interaction between staff and patients in the waiting room.

Good

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.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last five years. 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 two years and we were able to review these. Significant events were a standing item on the weekly practice meeting agenda. 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.

Staff used incident forms on the practice intranet and sent completed forms to the business manager. They showed us the system they used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken**.**

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 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 appointed a dedicated GP as lead in safeguarding vulnerable adults and children. He had been trained and was also a GP trainer, he could demonstrate he 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 to in the practice if they had a safeguarding concern.

There was an alert 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 or domestic violence issues.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

All GP's and staff had carried out the safeguarding training in regard to vulnerable children and adults and discussed improvements at a partners meeting. In addition the practice had provided training in how to recognise signs of domestic violence and how to escalate concerns to all staff and had a written protocol, this was in response to an identified need.

All GPs had a "usual doctor" list that enabled them to keep track of vulnerable persons and discuss their care and treatment at practice meetings. We were told that same day telephone consultations with those patients took place when required.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff who had been risked assessed and DBS

checked would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

National patient safety alerts were disseminated by the business manager to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at team meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Medicines management

The surgery was a dispensing practice and there was a full dispensing team lead by a dispensary manager

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.

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

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 practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a safe and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. If prescriptions were not signed before they were dispensed, staff were able to demonstrate that these were risk assessed and a process was followed to minimise risk. We saw that this process was working in practice.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice offered a medicines delivery service for patients for routine repeat prescriptions. The service was open to a number of patient groups, including housebound patients, patients aged 65 and over and the spouse of any patient aged 65 and over.

We saw that the practice were monitoring prescribing patterns and were taking action in response to issues identified.

Cleanliness and infection control

During the inspection we looked at the areas of the surgery used by the practice which included the GP consulting rooms, treatment rooms, store rooms, patient toilets and waiting areas. We observed the areas to be clean and tidy. We saw there were daily 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 used an in house cleaning team and the overall cleanliness of the practice reflected the work undertaken by that team.

The practice had a practice nurse who was the 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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last eight

years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed and acted on if required.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Each clinical room had clinical waste bins which were foot operated and lined with the correct colour coded bin liners. We saw disposable curtains were in each clinical room to ensure that patients had privacy when being examined. These had been replaced every six months in line with the infection control.

We saw that there were notices displayed in staff and patient toilet facilities about hand hygiene techniques. All sinks including those in treatment rooms had hand soap, hand gel and hand towel dispensers available.

The practice had a policy for the management, testing and investigation of legionella (water borne bacteria found in the environment which can contaminate water systems in buildings). 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. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, 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.

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 business 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 also had a health and safety policy.

Staff we spoke with knew it was important to report incidents and significant events to keep patients

safe from harm. They were aware of the most appropriate person to report their concerns to.

We saw that a log of incidents, complaints and significant events had been kept at the practice. We saw they had all been appropriately investigated. We saw that reviews of incidents and significant events over time had been completed to identify if there were any reoccurring concerns across the service**.**

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 saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the business manager had shared the recent findings from an infection control audit with the team.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

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.

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 (a sudden allergic reaction that can result in rapid collapse and death if not treated) and hypoglycaemia (low blood sugar).

Processes were in place to check whether emergency medicines were within their expiry date and suitable 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 contained relevant contact details for staff to refer to. For example, in the case of loss of the building the practice had a continuity plan with a 'buddy' system with another local practice.

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.

Risks associated with service and staffing changes were included on the practice risk log. For example planning and training sessions were implemented and reviewed during appraisals. Key monthly dates were held in the practice calendar to which all staff had access. Practice insurance provided payment for the absence of key personnel.

Good

Are services effective?

(for example, treatment is effective)

Our findings

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 local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. 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.

The GPs told us they led 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. GPs told us this supported all staff to continually review and discuss new best practice guidelines. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed by their GP according to need.

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 suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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 business manager to support the practice to carry out clinical audits.

The practice showed us seven clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, following an alert from the National Patient Safety Agency (NPSA) regarding actions that can make anticoagulant therapy safer an audit was carried out. The aim of the audit was to ensure that all healthcare organisations should have written procedures and clinical protocols for the safe use of oral and injectable anticoagulant therapy. We saw that the practice had copies of procedures, clinical protocols, dates of Drugs and Therapeutics Committee approval including review dates.

One of the recommendations was that safe practice was promoted with prescribers and pharmacists to check that patients' international normalised ratio (INR) was being monitored regularly and that this level was safe before issuing or dispensing repeat prescriptions for oral anticoagulants. INR is a laboratory measurement of how long it takes blood to form a clot. It is used to determine the effects of oral anticoagulants on the clotting system. The action taken was that an audit was performed every week using relevant reporting software. All patients more than six days overdue an INR test were contacted by letter to remind them to book an appointment.

The GPs told us clinical audits were often 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

Good

Are services effective?

(for example, treatment is effective)

long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal 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.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had a record of an albumin: creatinine ratio test in the preceding 12 months, this is used to identify kidney disease that can occur as a complication of diabetes and the practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, The percentage of patients aged 65 and older who have received a seasonal flu vaccination was the highest recorded within the CCG .

Effective staffing

Practice staffing included medical, nursing, dispensary, managerial and administrative staff. We reviewed staff training records and saw that all staff was up to date with attending mandatory courses developed by the practice such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all had 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 GMC 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 in children and vulnerable adult safeguarding. As the practice was a training practice, doctors who were training to be qualified as GPs had access to a senior GP throughout the day for support.

All practice nurses are qualified in the extended role of independent nurse prescribers. The practice is also a nurse training practice with the lead nurse and one other senior nurse being a qualified mentor/trainer.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles such as those seeing patients with long-term conditions like asthma, chronic obstructive pulmonary disease (COPD) and other conditions that affect breathing, diabetes and coronary heart disease were able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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 practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. 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 the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). 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 practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, 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 in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

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 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). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The Practice had been fully operational with the electronic Summary Care Record for three years being one of the first to adopt of this locally. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record 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 evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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) and had a section stating the patient's preferences for treatment and decisions. 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 all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing.

The practice offered NHS Health Checks to all its patients aged 40-74 years and it was evidenced to us that it was the second highest performer within Lincolnshire for those assessments.

The practice had numerous 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 (49) with a learning disability. Practice records showed all had received a health check up in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 84.2%, which was better than others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend annually. There was a named nurse responsible for following up patients who did not attend screening.

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 clear policy for following up non-attenders by the named practice nurse.

Blood can be taken on site and the practice also perform electrocardiograms (ECG) this records the electrical activity of the heart. The heart produces tiny electrical impulses which spread through the heart muscle to make the heart contract. These impulses can be detected by the ECG machine, spirometry this is used to diagnose asthma, chronic obstructive pulmonary disease (COPD) and other conditions that affect breathing and ambulatory blood pressure monitoring (ABPM) this is a non-invasive method of obtaining blood pressure readings over a 24-hour period, whilst the patient is in their own environment, representing a true reflection of their blood pressure. when requested by our doctors

Good

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 national patient survey. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect.

For example, data from the national patient survey in September 2014 showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses with 87% of practice respondents saying the GP was good at listening to them and 84% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 34 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Five comments were less positive but there were no common themes to these.

We spoke with six patients in the reception and waiting areas of the practice including patients from a number of different practice population groups. The majority of the patients we spoke with were very happy with the service they received. All of the patients we spoke with told us that the GPs and the nurses were caring, patient, kind and treated them with respect.

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 switchboard was located away from the reception desk in a separate office and therefore keeping patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the business manager. The business manager told us he would investigate these and any learning identified would be shared with staff.

The practice liaised with other appropriate agencies and signposted patients via the website, leaflets or advertisements on the screens in the waiting room.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 national patient survey taken in September 2014 showed 73% of practice respondents said the GP involved them in care decisions and 86% felt the GP was good at explaining treatment and results. Both these results were in line or slightly better than results nationally.

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.

Good

Are services caring?

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

Patient/carer support to cope emotionally with care and treatment

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, such as the NHS choices and National Blood Transfusion websites. 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. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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 NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patient surveys and audits.

The practice offered a dispensary service for eligible patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Bourne has a large eastern European population many of whom worked at the local food packaging and production factories.

The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been adapted to meet the needs of patient with disabilities. The practice was situated on the ground floor of the building with staff services on the first floor. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

We saw that 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.

People whose circumstances may make them vulnerable are easily able to register with the practice, including those with "no fixed abode" care of the practice's address, people not registered at the practice are able to access appointments through drop in services that are available.

Access to the service

Appointments were available from 8:30 am to 6pm on weekdays. They also were open from 7am to 8am on Tuesday mornings and on Thursday evenings from 6:30pm to 8pm for pre booked appointments only.

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.

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 when requested to seven local care homes and eight homes for persons with learning disabilities by a named GP.

The practice's extended opening hours on Tuesdays and Thursdays were particularly useful to patients with work commitments. This was confirmed by comments from patients who appreciated the ability to come in after work or before school.

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 in the practice booklet,

Good

Are services responsive to people's needs?

(for example, to feedback?)

displayed on the waiting room wall and on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at six complaints received in the last 12 months and found that these were satisfactorily handled, dealt with in a timely way, with openness and transparency when dealing with the compliant.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and one theme had been identified, that there was difficulty in obtaining appointments. This resulted in an audit of patient access and changes were made to policies and procedures thereafter.

Minutes of team meetings showing that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice charter stated that their mission was to provide an efficient, academically sound and compassionate service to the sick; to promote good health practices within the community and to enable each member of the team to obtain fulfilment of these aims, free from unnecessary personal, professional or economic stress.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when and this was tracked on the practice computer. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example a Diabetes Audit and Clinical Review and an audit on the use of a cholesterol lowering drug.

The practice had arrangements for identifying, recording and managing risks. The business manager showed us the risk log, which addressed a wide range of potential issues, such as electrical safety. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. This included an identified risk in the storage of combustible materials in the switchgear area. This is an area of the building where the electrical power system is housed and contains a combination of electrical disconnect switches, fuses or circuit breakers used to control, protect and isolate the building electrical equipment.

The practice held monthly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

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

The business manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the practice disciplinary procedures and the induction policy. which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the patient access audit after the practice had numerous comments received about inability to get appointments, waiting times and lack of continuity. The audit identified the problems and came up

Are services well-led?

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

with solutions resulting in a new system of appointments being implemented with 98% of patients now satisfied. The average wait to see a GP fell from nine days to less than one. The proportion of patients seen on the same day rose from 42% to 91%. Patients told us were now much happier with the appointments system.

The practice had a very large and active patient participation group (PPG) which had been in existence for a number of years. The PPG met every month and additionally held a six monthly away-day and AGM. All those meetings were attended by the Business Partner and a GP Partner. All meetings were minuted and available.

The PPG produced in conjunction with a neighbouring practice a booklet for patients that signposted organisations within the local area to assist patients. It also advised patients on when to use A&E and minor injuries units and when not.

The business manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

The PPG were also involved in day trips for patients who were housebound, provided hospital transport where needed and a listening ear for those patients who needed it. They supported the practice on campaigns such as flu vaccinations.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training around chaperoning at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice where they train qualified doctors to become General Medical Practitioners through a period of working and training in the practice and are part of the East Midlands Deanery. The practice was also a Nurse training practice in conjunction with the University of Lincoln.

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