Branston and Heighington Family Practice

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	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 Branston and Heighington Family Practice on 29 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, responsive, caring, effective services and for being well led.

We looked at patient care across the following population groups: Older people; those with long term conditions; families, children and young people; working age people(including those recently retired and students); people in vulnerable circumstances who may have poor access to primary care; and people experiencing poor mental health.

- 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, including those relating to recruitment checks.
- 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 were able to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice was equipped to treat patients and meet their needs, although we acknowledge that the restricted space available made the provision of further services difficult.
- 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.

However there were areas of practice where the provider needs to make improvements.

Summary of findings

Importantly the provider should;

- Ensure that any learning from significant events and complaints is recorded and cascaded to staff to help prevent re-occurrence.
- Establish a regular schedule of meetings for all staff at the practice.
- Improve access to the service for working age patients by offering extended opening times.

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.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's 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 appropriate training planned to meet these needs. There was evidence of appraisals and 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. Data showed that patients rated the practice higher than others for several aspects of care. 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 also 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 England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice 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.

Summary of findings

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. There was recently constituted patient participation group. Staff had received inductions, regular performance reviews and attended staff meetings.

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.

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.

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 and health visitors.

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

Summary of findings

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. However we noted that no appointments with GPs and nurses were available outside of normal hours.

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 all 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.

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). 88% 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. 90% of patients who had been diagnosed with dementia had received and annual review in the year to date.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. 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 in the Mental Capacity Act.

Summary of findings

What people who use the service say

During the inspection we spoke with patients and carers that used the practice and met with members of the patient participation group (PPG). A PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We also reviewed 29 comments cards that had been provided by CQC on which patients could record their views.

All the patients we spoke with, and all but one of the patients who had completed comments cards, emphasised the caring attitude of the staff and the quality and efficacy of the treatment and care they received.

They told us that the care and treatment they received was good and that they felt fully informed as to their treatment options. Their confidentiality and dignity was respected.

Patients said that the practice was clean and staff practiced good hygiene techniques.

Five of the respondents had said that getting an appointment was difficult at times.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that any learning from significant events and complaints is recorded and cascaded to staff to help prevent re-occurrence.
- Establish a regular schedule of meetings for all staff at the practice.
- Improve access to the service for working age patients by offering extended opening times.

Branston and Heighington Family Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Branston and Heighington Family Practice

Branston and Heighington Family Practice offers a range of primary medical services from a surgery at Station Road, Branston, Lincoln. There is also a branch surgery at 7a High Street, Heighington. This surgery was not open on the day of our inspection and was not visited.

On the day of our inspection the patient list was 5,993. The patient population has a relatively low depravation score of 9.6 compared to the national average of 21.3.

It is located within the area covered by Lincolnshire West Clinical Commissioning Group. A CCG is an organisation that brings together local GP's and experience health professionals to take on commissioning responsibilities for local health services.

The practice is staffed by four GPs, consisting of two partners and two salaried GPs. Two GPs are male and two female. The practice employs three practice nurses and one healthcare assistant. They are supported by a practice manager, receptionists and a range of administrative and support staff. Cleaning was provided by the practice's own employed staff.

The practice dispensed to 1,203 eligible patients by a team of three dispensers.

The surgery is open from 8.30 am until 6 pm Monday to Friday, with GP consultations available from 8.30 am to 12 noon and 3.30 pm until 6 pm. The surgery closed every day for lunch from 1 pm to 2 pm.

The practice has opted out of the requirement to provide GP consultations when the surgery is closed. The out-of-hours service is provided by Lincolnshire Community Health Services NHS Trust.

Prior to our inspection we consulted with the clinical commissioning group (CCG) and the NHS England Area Team about the practice. A CCG is an organisation that brings together local GPs and experienced health professionals to take on commissioning responsibilities for local health services.

The practice was last inspected by the Care Quality Commission in May 2014, when it was judged to be in breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 The practice did not have in place effective systems to monitor the quality of the service provided. This related to a failure to regularly seek the views of patients, failing to manage identified risk, ineffective recruitment procedures and failing to provide staff with adequate appraisal and supervision.

During this inspection we spoke with patients and carers that used the practice and met with members of the patient participation group (PPG). A PPG is a group of

patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We also reviewed comments cards that had been provided by CQC on which patients could record their views.

Why we carried out this inspection

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

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice.

We carried out an announced visit on 29 January 2015. During our visit we spoke with two GPs, a nurse, the practice manager and a receptionist. We spoke with patients who used the service. We observed the interactions between patients and staff, and talked with carers and family members. We met with representatives of the patient participation group (PPG). The PPG is a group of patients who have volunteered to represent patients' views and concerns and are seen as an effective way for patients and GP surgeries to work together to improve services and to promote health and improved quality of care.

We reviewed 29 CQC comment cards where patients had shared their views and experiences of the service.

In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice. We also reviewed information we had received from Healthwatch, NHS Choices and other publically accessible information.

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

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

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

- Older people
- People with long-term conditions
- 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)

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 13 months. This showed the practice had managed these consistently over time and 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. We reviewed the records of significant events that had occurred during the last 13 months. They had been recorded in a comprehensive and timely manner. Significant events were discussed at practice and clinical meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff through clinical and staff meetings. For example we saw how the practice had reflected upon a case of a patient with a serious throat condition and the senior partner, who had a special interest in ear, nose and throat medicine, had made a presentation at a clinical meeting to raise awareness and better diagnosis. Similarly a death resulting from a very rare condition was also discussed and a presentation made to clinical staff to give a better understanding of how to recognise the condition.

National patient safety alerts were disseminated by the practice manager to practice staff. They were required to sign them as read before being returned to the practice manager. Staff we spoke with were able to give examples of recent alerts, for example the outbreak of the Ebola virus in West Africa. They also told us alerts were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems in place to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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 appointed dedicated GPs as leads 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 these leads were 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.

We viewed the practice chaperone policy. (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). Notices to patients, alerting them to their choice of having a chaperone, were visible on the reception area noticeboard and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. They had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

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. We saw evidence of a weekly stock take of vaccines and stock rotation.

The senior partner attended quarterly meetings with the CCG pharmacy team and used Lincolnshire Prescribing and Clinical Effectiveness Forum (PACEF) bulletins and guidance to ensure the effective use of medicines. (PACEF is a strategic advisory network with the responsibility for ensuring the cost-effective use of medicines and other healthcare interventions and their functional integration into healthcare delivery across Lincolnshire.)

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.

Repeat prescriptions could be ordered by email, in person or by written means, there was a box in the reception area to receive such requests. 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.

Dosette boxes were used to enable patients who may be at risk thorough such conditions as dementia or learning disability to self-medicate safely and take their medicine at the right time and on the right day.

Patients suffering mental ill health and taking lithium were monitored as part of their annual health checks.

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 controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs through the local Police.

Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary.

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

Cleanliness and infection control

The practice employed its own cleaners as opposed to employing a contract cleaning company. We observed the premises to be very clean and tidy, free of clutter and there were no unpleasant smells. Carpeted areas in reception and corridors were free from stains and spillages.

We saw there were daily, weekly and monthly cleaning schedules in place and records were kept. The practice manager carried out a monthly audit of the premises to ensure that cleaning was being carried out effectively.

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. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that an outside provider had been employed to undertake an infection prevention and control audit and that any improvements identified for action were completed on time. We saw that the next audit had already been arranged.

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 a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Adequate supplies of soap, hand gel and hand towels were present in staff and public toilets.

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 and that it had been discussed at a staff meeting.

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 that had been completed by an external company.

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. Suitable arrangements were in place for staff absence though annual leave to be covered.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. 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. The practice held meeting at the beginning of every day, before patients arrived, which had a set agenda covering subjects for the day such as staffing, dispensary and reception issues, check on the location of emergency equipment, test of the panic alarms , any reported patient deaths and planned visitors.

Other risk assessments included checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

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 we saw that the practice had a completed fire risk assessment and had undertaken fire drills, including a full evacuation. We saw evidence that there was some learning derived from the exercise that had been cascaded to all staff.

The practice manager had completed a course in fire safety management. Together with another member of staff they had the role of fire marshals.

Arrangements to deal with emergencies and major incidents

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

Good

Are services safe?

defibrillator was housed in a box outside of the surgery and was provided and maintained by East Midlands Ambulance Service. All staff were aware of the lock number required to access the equipment.

During the course of our inspection a medical emergency occurred involving a child in the reception area. The panic alarm was activated and we saw how staff and GPs responded immediately to render effective assistance.

Emergency medicines, for example those used for the treatment of anaphylaxis and hypoglycaemia, were available in a secure area of the practice and all staff knew of their location. 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. All staff had received training in basic life support in December 2014.

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.

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, including a full evacuation of the surgery.

Good

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

The data from the local CCG of the practice's performance for antibiotic prescribing was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

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 to secondary and specialist services, for example patients with suspected cancers referred and seen within two weeks.

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 medicines management.

The practice showed us clinical audits that had been undertaken in the last two years. These included audits regarding minor surgery, prostatic specific antigens (PSA), osteoporosis fragility fractures and gout. We saw that learning from those audits had included patients undergoing a PSA test were now given comprehensive written information regarding testing for prostate cancer.

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 long-term conditions and for the implementation of preventative measures.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 84% of patients with diabetes had an annual medication review in the year to date, and the practice met all the minimum standards for QOF in

asthma and chronic obstructive pulmonary disease (lung disease) This practice was not an outlier for any QOF (or other national) clinical targets.

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.

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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines

Good

Are services effective?

(for example, treatment is effective)

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. Where they continued to prescribe it the GP 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 practice for each patient's needs.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal clinical 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 CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. his benchmarking data showed the practice had outcomes that were comparable to other services in the area.

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 with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with, for example, the senior partner having a special interest in ear, nose and throat (ENT) medicine and was accredited to carry out ENT consultations. The GP held two outpatient sessions a month at the local general hospital to help maintain their links and expertise. The GP also offered ENT services to patients at the practice but also from neighbouring practices as an additional service. Other GPs held a Diploma in family planning and had an interest in drug and alcohol misuse, learning disability and osteoporosis.

One GP partner and two of the nurses belonged to the Primary Care Respiratory Society which enabled them use the latest evidenced based medicine to improve the management of respiratory disease.

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 in spirometry, a test that can help diagnose various lung conditions, most commonly chronic obstructive pulmonary disease.

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, for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

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 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. All such correspondence was dealt with by a team of data clerks who flagged any tasks up to individual clinicians using the computer system, who were then responsible for actioning the task. The practice operated a 'buddy' system with GPs covering each other's tasks in their absence or unavailability. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings every two or three months 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. We saw minutes of the meetings and noted that they were comprehensive and well structured.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made of referrals last year 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 and one GP we spoke with told us they used the 'Choose and Book' system at the time of the consultation to help patients make an informed choice.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, SystmOne, 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.

The ambulance service and the out-of-hours provider both used SystmOne and this enabled the efficient and timely transfer of patient information between the three healthcare providers.

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, in which they were involved. 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. All of the staff and clinicians we spoke with 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) and signs were displayed on the noticeboard and behind reception remind to implement it correctly.

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. Written consent was also obtained and we saw redacted consent forms that showed this to be the case.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years with the aim of the prevention and early diagnosis of disease.

All patients aged 75 or over had a named GP to promote continuity of care.

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 with a learning disability with eight on the register. All had received an annual physical health check at the same time as they were reviewed for other co-morbidities. The practice also had a register for patients who had mental ill-health problems. 88% had been offered and received an annual physical health check in the year to date.

The practice's performance for cervical smear uptake was 86%, 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.

Good

Are services effective?

(for example, treatment is effective)

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 there was a clear policy for following up non-attenders by a named practice nurse.

The practice sent all child patients a birthday card on their first birthday to remind parents to make an appointment for the child to receive their booster vaccinations.

The practice held an annual influenza immunisation day that was held in the village hall on a Saturday. The events had been supported by Age UK, the local hospice and this year's event by Lincolnshire Fire and Rescue Service. Uptake of the vaccine was high and the practice also took the opportunity to offer all patients over 65 a check for atrial fibrillation in order to try and prevent the prevalence of strokes.

We saw that when patients attained the age of 75 they were sent a birthday card by the practice. This among other things, directed patients to other services that could assist them, for example respite care and help with shopping and lifestyle choices and directing them to the fire and rescue service for a free home fire risk assessment.

A large comprehensive school was located very close to the practice and one of the GP partners told us how they were working with the school to try and increase the uptake of teenage immunisations.

Screening for chlamydia was offered at the practice as well as a specialist clinic in Lincoln.

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 GP patient survey, and the results from the Family and Friends test undertaken in December 2014. The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, the national GP patient survey showed the practice was rated as average when compared to national data for patients who rated the practice as good or very good. The practice was also rated as average for its satisfaction scores on consultations and with respondents who said the GP was good at listening to them and GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 29 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 the common themes being the difficulty in getting thorough on the telephone to make an appointment. We also spoke with five 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 viewed the practice policy of respecting patients' privacy and confidentiality and saw that staff were careful to follow it when discussing patients' treatments. The reception area was open, but music was played to help mask conversations between receptionists and patients. We observed a receptionist take a patient to a quieter area of the reception desk to ensure confidentiality. There was an area near to the reception desk that could be used for private conversations. However there was no room near reception to be used for the purpose. We were told by reception staff that if they were free clinical rooms can be used for this. Conversations in treatment rooms could not be overheard.

Staff told us that 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 practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

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 GP patient survey showed that respondents said the GP involved them in care decisions. They also felt the GP was good at explaining treatment and results were in line with the national 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 were 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. We saw notices in the reception areas informing patents this service was available.

Staff we spoke with told us that teenagers were encouraged to discuss any matters they wished when they attended for their booster immunisation appointment.

The practice operated an open door policy for teenagers, with access to appointments at all times, including after school.

Good

Are services caring?

We saw that the practice had developed personalised care plans for patients identified as being most as risk. We saw evidence of advanced directives for patients in nursing homes and for patients in palliative care. Evidence of the discussions and appropriate consent was recorded.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, and on the practice 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. Patients received a birthday card from the practice on their 75 birthday, which directed them and their families to additional support for carers, including respite care.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was followed by a visit to the relatives to meet the family's needs by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients needs and had systems in place to maintain the level of service provided. The needs of the practice population 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. We saw minutes of meetings for example of the practice partners meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

The practice had recently established a patient participation group. We spoke with the chair and secretary who told us that one of the aims of the group was to gauge and assess patient satisfaction and needs. This information would be feedback to the practice in an effort to improve the service.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example, there was a large traveller site nearby and the practice had some of the travellers registered as patients.

The practice had access to online and telephone translation services and a notice in the reception area made patients aware of the facility. The practice website had a translate option.

The practice had an equality and diversity policy which was available for patients to view on their website. Equality and diversity training was provided to staff through e-learning. Staff we spoke with confirmed that they had completed the training.

The practice was situated on the ground and first floors of the building with all services for patients on the ground floor. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. This allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

Guide dogs for patients and carers with impaired vision were welcomed into the surgery

Access to the service

The surgery was open Monday to Friday from 8.30 am to 6 pm daily, closing for lunch from 1 pm to 2 pm. The senior partner told us that they were working on staff flexibility to allow appointments up to 8 pm to cater for working age people but this was still in development.

Receptionists had been instructed to gain as much information from patients as they could when asking for an appointment. This enabled them to establish if a longer appointment than the regular ten minutes was required. Receptionists told us that patients were not pressured into disclosing medical and personal information but that asking was a valuable tool in managing the demand for appointments with GPs and nurses.

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 to local care homes, by a named GP and to those patients who needed one.

Emergency same day appointments were given for those patients suffering from mental health problems and in crisis. Those who had attended a hospital accident and emergency department as a result of deliberate self harm or attempted suicide were notified to the practice, who contacted them and offered them an appointment to see a GP.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that those in urgent need of treatment had often been able to

Good

Are services responsive to people's needs?

(for example, to feedback?)

make appointments on the same day of contacting the practice. Five of the comments cards we received expressed dissatisfaction at accessing the service, as a result of the telephone lines being constantly engaged. The practice manager told us that there were two incoming phone lines that enabled patients to book appointments and that two members of staff took calls from these lines. Data from the national GP patient survey showed that respondents were generally satisfied with telephone access and the results were in line with the national average.

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 that was displayed in the patient reception and waiting and on the practice website. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the seven written complaints received in the last 12 months and found they had been satisfactorily handled, dealt with in a timely way and with openness and transparency when dealing with the complainant.

The practice had reviewed the complaints to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, issues raised from individual complaints had been acted on and any learning cascaded to staff.

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 and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and plan going forward. We were told by the senior partner that the practice had outgrown the current building and it had proved extremely difficult to offer additional service or clinics due to the constraints of the building. They told us that they saw federation with neighbouring practices as the most sustainable business model and they were actively looking at a nearby site with a view to constructing a new surgery. Minutes of the partners meetings reflected this view.

Members of staff we spoke with all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The practice mission statement was displayed prominently on the practice website.

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 a range of these policies and procedures and found them to be relevant and regularly reviewed

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

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

We saw that the practice manager displayed in a prominent positon current data that related to such things as the number of patients attending out-of-hours services, walk-centres, accident and emergency and referral rates to secondary care. The practice manager told us that this was to keep staff informed of the current situation but that he now intended to audit those figures to try and identify the cause for such attendances.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

There were arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. We saw that the risk log was regularly discussed at 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, for example a fire risk assessment.

The practice held a daily early morning safety briefing for all staff to constantly assess and manage ongoing risk.

Leadership, openness and transparency

We saw from minutes that team meetings were held but that the frequency had been sporadic. The practice manager told us that they were aware of that and it was the intention of the partners that meetings involving all of the practice staff should become more frequent. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as that on managing sickness and harassment and bullying which were in place to support staff. We were shown the electronic staff handbook that was available to all staff on computers within the practice. Hard copies were also available. Staff we spoke with knew where to find these policies if required.

Appropriate policies were available for the public to view on the practice website.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through the GP patient surveys and complaints received.

The practice had formed a patient participation group (PPG) in December 2014 which had met twice to elect its

Are services well-led?

Good

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

chairman and secretary and decide on its role. We met with the chair and secretary who explained to us the view of what the PPG should do and how they hoped to compliment and assist the practice.

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. 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 four 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 guest speakers and trainers had been into the practice to instruct staff.

The practice had completed reviews of significant events and other incidents but there was little evidence of learning from these events being cascaded to all staff.