Dr Ashworth and Partners (Bryn Cross Surgery)

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?	Outstanding

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

Bryn Cross Surgery was inspected on the 10 November 2014. This was a comprehensive inspection. This means we reviewed the provider in relation to the five key questions leading to a rating on each on a four point rating scale. We assessed all six of the population groups and the inspection took place at the same time as we inspected a number of practices in the area overseen by Wigan Clinical Commissioning Group (CCG).

We rated Bryn Cross Surgery as good in relation to being safe, effective, caring and responsive and outstanding in relation to being well-led.

Our key findings were as follows:

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and 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 people safe.

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned. The practice could identify all appraisals and personal development plans for all staff. Multidisciplinary working was evidenced.

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical

Summary of findings

Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other external organisations.

The practice is rated as outstanding for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active patient participation group (PPG).

There were areas where the practice should improve. For example:

there was a failure to adopt in full the recruitment checks that the practice policy outlined;

there was a general lack of understanding of capacity issues and best interest meetings;

chaperone arrangements were not effective;

fire drills, fire Marshalls and fire safety training was not in place;

whistleblowing awareness was lacking in some staff.

We noted some outstanding practice including:

an excellent triage system now identified as best practice by the CCG;

a strong focus on protected learning time, peer review and mentoring for staff at all clinical levels;

an excellent initiative to identify and review via multi-disciplinary meetings the most unwell patients;

an excellent annual review system for patients with long term conditions;

an effective patient participation group (PPG) with locality forums and training for members.

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 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 people 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. NICE guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included the promotion of good health. Staff had received training appropriate to their roles and further training needs were identified and planned. The practice could identify all appraisals and personal development plans for all staff. Multidisciplinary working was evidenced.

Are services caring?

Good

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Summary of findings

Are services well-led?

Outstanding 

The practice is rated as outstanding for providing well led services. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with external organisations and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there was a high level of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active patient participation group (PPG).

Summary of findings

What people who use the service say

We received 41 completed patient comment cards and spoke with fifteen patients at the time of our inspection visit. We spoke with people from all the population groups.

Patients we spoke with and who completed CQC comment cards were positive about the care and treatment provided by the clinical staff and the assistance provided by other members of the practice team. They told us that they were treated with respect and that their dignity was maintained. Some said that the privacy in the reception area could be improved.

We also looked at the results of the 2014 GP patient survey. This is an independent survey run by Ipsos MORI on behalf of NHS England. The survey results included;

97% of respondents found the receptionists at the practice helpful

99% of respondents said the last appointment they got was convenient

99% of respondents said the last GP they saw or spoke to was good at listening to them

98% of respondents described their overall experience of this surgery as good

Areas for improvement

Action the service SHOULD take to improve

There was a failure to adopt in full the recruitment checks that the practice policy outlined

There was a general lack of understanding of capacity issues and best interest meetings

Chaperone arrangements were not effective

Fire drills, fire Marshalls and fire safety training was not in place

Whistleblowing awareness was lacking in some staff

Outstanding practice

Excellent triage system now identified as best practice by the CCG.

Strong focus on protected learning time, peer review and mentoring for staff at all clinical levels.

Excellent initiative to identify and review via multi-disciplinary meetings the most unwell patients.

Excellent annual review system for patients with long term conditions.

Effective patient participation group (PPG) with locality forums and training for members.

Dr Ashworth and Partners (Bryn Cross Surgery)

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team consisted of a CQC Lead Inspector and two specialist advisors (a GP and a practice manager). Our inspection team also included an Expert by Experience who is a person who uses services them self and wants to help CQC to find out more about people's experience of the care they receive.

Background to Dr Ashworth and Partners (Bryn Cross Surgery)

Bryn Cross Surgery is located on the main A49 Wigan Road in Ashton in Makerfield. At the time of this inspection we were informed 5,880 patients were registered with the practice.

The practice consisted of: one senior partner (female), two salaried GPs (one female, two male), one locum GP (male) and a registrar (a male trainee GP). These GPs are providing general medical services to registered patients at the practice. The GPs are supported in providing clinical services by a nurse practitioner (female), a practice nurse (female) and a health care assistant (HCA) (female) . Clinical staff are supported by the practice manager and his team who are responsible for the general administration and organisation of systems within the practice.

The practice is part of the health locality group Atherleigh & Patient Focus (ALPF) which consists of 24 GP practices who regularly meet to share information and identify best practice.

Out of hours service is provided by Claire House. Tel: 01942 829911

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 (QOF) data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

- Is it safe?

Detailed findings

- 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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 10 November 2014. During our visit we spoke with GPs, nursing staff, the practice manager and reception staff, we also spoke with patients who used the service and a member of the patient participation group (PPG).

We saw how staff interacted with patients and managed patient information when patients telephoned or called in at the service. We saw how patients accessed the service and the accessibility of the facilities for patients with a disability. We reviewed a variety of documents used by the practice to run the service.

Are services safe?

Our findings

Safe track record

There were clear lines of leadership and accountability in respect of how significant incidents were investigated and managed. Before visiting the practice we reviewed a range of information we hold about the practice and asked other organisations such as NHS England and the Clinical Commissioning Group (CCG) to share what they knew. No concerns were raised about the safe track record of the practice. Discussion with senior staff at the practice and written records of significant events revealed that they were escalated to the appropriate external authorities such as NHS England or the CCG. A range of information sources were used to identify potential safety issues/incidents. These included complaints, health and safety incidents, findings from clinical audits and feedback from patients. We saw one example of a needle stick injury and how it had been very comprehensively and effectively dealt with. We noted that there was a very open and transparent attitude to identifying and learning from significant event and incidents, which meant that the opportunities to improve and become safer were maximised.

The practice had a system for managing safety alerts from external agencies. For example those from the medicines and healthcare products regulatory agency (MHRA). These were reviewed by the GPs, practice nurse and practice manager and action was taken when required.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. Significant incidents and events were used as an opportunity for learning and improving the safety of patients, staff and other visitors to the practice. We spoke with staff from across the practice team. They told us that the culture at the practice was open and fair and that they were encouraged to report incidents or mistakes and were supported when they did so. The examples we looked at showed how incidents were investigated by defining the issue and identifying what actions needed to be taken to address the risk and minimise or prevent it from happening again. We were told and confirmed from records that learning from significant events was discussed at practice staff meetings which were held every Tuesday. Reception staff we spoke to told us that they received indirect feedback from meetings via the practice manager. They told us that they would prefer to be able to attend these meetings occasionally. We discussed this with the practice manager and he agreed that this could be facilitated.

Information from the quality and outcomes framework (QoF), which is a national performance measurement tool, showed that in 2013-2014 the provider was appropriately identifying and reporting significant events. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. We looked at one example relating to the theft, we saw it was comprehensively recorded and the appropriate authorities were summoned to investigate the matter, the incident was reviewed and measures put in place to reduce the likelihood of a similar occurrence.

Reliable safety systems and processes including safeguarding

Safeguarding policies and procedures for children and vulnerable adults had been implemented at the practice. The senior partner GP took the lead role for safeguarding. Their role included providing support to their practice colleagues for safeguarding matters and liasing with external safeguarding agencies, such as the local social services and CCG safeguarding teams and other health and social care professionals as required.

Staff training records demonstrated that clinical and non-clinical staff had been provided with regular safeguarding training in respect of vulnerable children and adults. In line with good practice enhanced (level 3) safeguarding training had been completed by the GP safeguarding lead. Staff we spoke with were able to describe how they could keep patients safe by recognising signs of potential abuse and reporting it promptly. Staff were less aware of how to raise issues about staff within the practice via the whistleblowing procedure. We spoke to the practice manager about this and they told us that additional training and signposting would be provided.

Reception staff were available to chaperone patients who requested this service. We did not see any evidence of training and although the lead GP told us that informal training was planned, we had doubts about the receptionist's ability to recognise appropriate clinical examinations. When we spoke to reception staff they told

us that whist performing chaperone duties they would stay behind the privacy curtain, this added to our concerns relating to their effectiveness as a chaperone should an incident occur.

Medicines management

Systems were in place for the management, secure storage and prescription of medicines within the practice. We looked at some audits of prescriptions and medicines and found them to be well documented, clear and up to date. Prescribing of medicines was monitored closely and prescribing for long term conditions was reviewed regularly. We looked at the medicine management file and found it to be comprehensive and in excellent order. A procedure was operated to enable patients to request and obtain their repeat prescriptions. Any medicines errors were treated as significant events. The lead GP told us that the Greater Manchester medicines team came to the practice on a weekly basis to offer advice and review medicines management within the practice. This displayed excellent communication links and provided the practice with an objective view of the efficiency and effectiveness in which it managed its medicines.

We looked at the processes and procedures for storing medicines. This included vaccines that were required to be stored within a particular temperature range. There was a clear policy for maintenance of the cold chain with actions to be taken in the event of any potential failure. We found appropriate action had been taken to achieve this and regular checks and records were made to ensure the appropriate temperature range was maintained. We saw that a comprehensive, clear documented system was in place to regularly check the medicines contained in the doctor's bags taken when visiting patients at home. This was to ensure the required medicines were present and within their expiry date. We noted that each GP had preference for which emergency drugs they preferred to be available to them. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. No controlled drugs were kept on site.

Cleanliness and infection control

Systems were in place for ensuring the practice was regularly cleaned. We found the practice to be clean at the time of our inspection. A system was in place for managing Infection prevention and control. We saw that audits relating to infection control had been completed by the nurse practitioner; this was done to ensure actions taken to prevent the spread of potential infections were maintained.

We also saw that practice staff were provided with equipment (for example goggles, disposable gloves and aprons) to protect them from exposure to potential infections whilst examining or providing treatment to patients. These items were seen to be readily accessible to staff in the relevant consulting/treatment rooms. We noted a urine sample ready for testing on a filing cabinet. We spoke to staff about this and they told us that no formal policy was in place for staff handling urine samples. Some reception staff that we spoke to told us that they did not always wear protective gloves when handling urine samples, but did always wash their hands after handling such samples.

We looked at the treatment room used for carrying out minor surgical procedures. We found this room to be clean and fit for purpose. Hand washing facilities were available and storage and use of medical instruments complied with national guidance. We looked at medical equipment that was stored in readiness for use and found that it was all within the manufacturers' recommended use by date.

Appropriate arrangements were in place to dispose of used medical equipment and clinical waste safely. Clinical waste and used medical equipment was stored safely and securely before being removed by a registered company for safe disposal. We saw records that detailed when such waste was removed.

Equipment

There were contracts in place for annual checks of fire extinguishers, portable appliance testing and calibration of equipment such as spirometers to measure lung capacity and nebulisers used to help breathing. Documentation evidenced that equipment was regularly inspected to ensure it remained effective.

Staffing and recruitment

The practice was staffed to enable the personal medical service needs of patients to be met. The staff team were well established and most had worked at the practice for many years. Reception staff told us that due to the office manager having left several months ago, there had been a gap in management which had resulted in the practice manager becoming more knowledgeable about their day

to day working. Management at the practice told us that they had just successfully recruited a new office manager. The staff we spoke to demonstrated excellent knowledge of clinical systems and processes.

We looked at staff recruitment practices and records. Whilst a formal recruitment process and policy was in place we found that staff personnel records did not include all of the information required to demonstrate that safe recruitment practices were being operated at the practice. For example we looked at the personnel record of the most recently recruited staff member (non-clinical). This did not contain proof of identity (including a recent photograph) or any written references. The practice should take action to ensure that people who use the service are protected by operating effective recruitment and selection procedures that includes relevant checks being carried out (and evidenced) when staff are employed.

The practice GPs covered each other's absence as much as possible and a locum agency was rarely used. When locum cover was required GPs who were known to the practice were mostly used and patients reported continuity even when referring to locum GPs. In the event of the practice having to use an unknown locum GP, then a full handover of information was available.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medications, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. There was an incident and accident book and staff knew where this was located. Staff reported that they would always speak to the practice manager if an accident occurred. All events and incidents were discussed at staff meetings and as reception staff did not attend these meetings, any feedback was given by the practice manager verbally or by email. The practice also had a health and safety policy, which staff had read and signed to say that they had understood its contents.

The practice manager was responsible for managing expected and unexpected absences which could cause disruption to the running of the practice. Staff were multi-skilled and were able to quickly cover each other's roles in the event of unforeseen absence. Most of the staff at the practice had been employed for many years and knew the patients well. Staff we spoke to told us they were able to identify if patients were unwell or in need of additional support, they told us that this meant that they could make arrangements for the patient to be helped accordingly

Arrangements to deal with emergencies and major incidents

A written contingency plan was in place to manage any event that resulted in the practice being unable to safely provide the usual services. The plan was kept in the staff kitchen and was available for all staff. Each member of staff we spoke to was aware of the policy relating to emergency procedures. This demonstrated there was a proactive approach to anticipating potential safety risks, including disruption to staffing or facilities at the practice.

Basic life support training was done every year with all staff and clinical staff undertook training in anaphylaxis. We spoke with staff who had been trained and they knew what to do in the event of an emergency such as sudden illness or fire. We saw emergency equipment and emergency drugs which were available and up to date and staff knew where these could be located. Fire drills and fire safety training were not routinely held and no fire Marshall had been identified. We talked to the practice manager and they agreed that these would be introduced.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients we spoke with said they received care appropriate to their needs. They told us they were involved in decisions about their care as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and cardiovascular and other regular health checks and screenings were on-going in line with national guidance. The practice had a documented system for reviewing patients with specific conditions. Members of reception staff took responsibility for different groups and ensured that they received prompt reminders of annual checks. Follow up communications were made if patients did not respond to initial contacts. Each group of people identified had a dedicated health care professional, with specific skills to review their condition. Appointment lengths were appropriate to the type of review taking place. Patients with multiple conditions were allocated longer appointments in order to review their more complex needs. These annual reviews were related to patients with ten specified conditions including: asthma, cardio obstructive pulmonary disease (COPD), learning disabilities, diabetes, mental illness and arterial fibrillation.

Multi-disciplinary meetings were held regularly to discuss individual cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions. Clinical staff discussed NICE guidance at weekly meetings and local forums where appropriate. The practice clinical computer system (Vision) prompted clinicians on potential guidance. We were told that the practice had modified these templates as they had gathered additional knowledge.

We saw that the practice was involved in a local initiative, where they utilised a risk tool to identify the top 2% of patients with the highest disease burden. Multi-disciplinary meetings were held weekly to examine two of these patient cases a week in order to share knowledge and skills to identify and improve outcomes for those patients.

Management, monitoring and improving outcomes for people

The practice was highly proactive in completing clinical audit cycles. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw several recent examples of these at the practice relating to warfarin (a blood thinning medicine), minor surgery, amitriptyline (a medicine used to treat depression), repeat prescribing and sinusitis as well as several other regularly used medicines.

We saw evidence of individual peer review and support and practice meetings being held to discuss issues and potential improvements in respect of clinical care. These meetings were well documented and clear. These peer reviews were occurring at all clinical levels at the practice and were a valuable method of ensuring that treatment and advice given by clinicians was effective.

The GPs, practice nurse and administration staff had developed areas of expertise and took the lead in a range of clinical and non-clinical areas such as palliative care and safeguarding children and vulnerable adults. They provided advice and support to colleagues in respect of their individual area.

Feedback from patients we spoke with, or who provided written comments, was complimentary and positive about the quality of the care and treatment provided by the staff team at the practice.

Effective staffing

The practice was currently reviewing its recruitment procedures which did require some improvement. We looked at staff induction and saw that this was comprehensive. It included training on data security, stress policy, moving and handling and sickness. We noted that support for staff including regular mentoring sessions was seen as a priority and protected learning time was provided to all clinical staff. We saw that staff had been given the opportunity to develop within the practice including developing from administration staff to clinical. We saw this as effective management as it retained skilled staff, created motivation and allowed continuity of staff for patient experience

Staff training records and discussions with staff demonstrated that all grades of staff were able to access regular training to enable them to develop professionally and meet the needs of patients effectively. New staff were provided with a programme of induction that included

Are services effective?

(for example, treatment is effective)

training relevant to their role. We saw that appraisals took place annually. However a more rigorous documented system of supervision meetings between appraisals would have been more effective in demonstrating staff support. Staff we spoke with said they being supported to access relevant training that enabled them to confidently and effectively fulfil their role.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrated to their regulatory body, the general medical council (GMC), that they were up to date and fit to practice. The GPs we spoke with had undergone recent clinical appraisals. The nurse practitioner confirmed that she was also supported to attend updates to training that enabled her to maintain and enhance her professional skills. She told us how well she had been supported by the senior partner at the practice whilst undertaking a degree.

Working with colleagues and other services

Systems were in place to ensure patients were able to access treatment and care from other health and social care providers where necessary. This included where patients had complex needs or suffered from a long term condition. There were clear mechanisms to make such referrals in a timely way and this ensured patients received effective, co-ordinated and integrated care. Information was shared with the CCG via a sharepoint portal and face to face meeting when appropriate. There was a great deal of information available on support groups and locally available clinics. We saw that staff were promoting these additional services as a method of assisting patients with particular issues, for example weight loss, bereavement and mental illness.

The regular weekly clinician meetings was a forum to discuss which cases required a multi-disciplinary approach. We saw that clinicians at the practice utilised a multidisciplinary approach in the care and treatment of their patients. This approach included regular meetings with professionals such as health visitors to discuss complex cases, and nurses to co-ordinate the care of patients coming to the end of their life. We saw that effective systems were in place to deal with referrals to and discharges from hospital.

Information sharing

GPs met every Tuesday with the practice nurses, other clinical staff and the practice manager. Information about risks and significant events was shared openly and honestly at these meetings.

The lead GP attended CCG meetings and disseminated what they had learned in practice meetings. This kept all staff up to date with current information around enhanced services, requirements in the community and local families or children at risk. Patients and individual cases were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend meetings. The GPs and the practice manager attended local community meetings. Feedback from community meetings was shared with practice staff where appropriate.

There was a practice website with information for patients including signposting, the PPG and seasonal initiatives. The PPG had become an effective method of communication information between the patients and practice staff; we saw that the minutes of the PPG meetings were available on the practice website. Information leaflets available within the practice waiting room and several folders containing an array of support information were also available in the waiting area. During our inspection we saw that patients regularly looked at information in these folders.

Consent to care and treatment

Patients we spoke with told us that they were spoken to appropriately by staff and were involved in making decisions about their care and treatment. They also said that they were provided with enough information to make a choice and gave informed consent to treatment.

The 2014 national GP patient survey indicated 94% of people at the practice said the last GP they saw or spoke to was good at explaining tests and treatments, 98% said the last GP they saw or spoke to was good at treating them with care and concern and 90% had confidence and trust in the last nurse they saw or spoke to.

Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. However there was no evidence of clinical staff having received training on this subject. People were supported to make decisions and, where appropriate, their mental

Are services effective?

(for example, treatment is effective)

capacity was informally assessed, however this was not recorded. Where people lacked the mental capacity to make a decision, best interests decisions were made but again these were not recorded. (Best interests meetings are when decisions are arrived at by the people who are best placed to know what is best for a person, for example a clinical expert when a medical decision is required). Clinical staff we spoke with lacked the understanding of the importance of obtaining informed consent from patients, however there was no evidence that patient's best interest were not being met.

Health promotion and prevention

New patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to quickly identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma. The practice nurses conducted the initial health screening assessments and made referrals to the GP for further assessment as appropriate.

A comprehensive range of health promotion information was available and accessible to patients particularly in the patient waiting areas of the practice. This was supplemented by advice and support from the clinical team at the practice. Health promotion services provided by the practice included smoking cessation and weight management. The practice had arrangements in place to provide and monitor an immunisation and vaccination service to patients. For example we saw that childhood immunisation and influenza vaccinations were provided. Extra appointments were made available during the winter months in an initiative called Winter Pressure. Flu vaccination promotion was publicised around the reception area as well as on the practice website. The practice was actively participating in providing NHS health checks for patients aged 40 to 74.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke to 15 patients in person and received feedback from 41 via completed CQC comments cards. Information we received from patients reflected that practice staff were professional, friendly and treated them with dignity and respect. Patients spoke highly of the practice, the reception staff and the doctors. One patient went out of their way to tell us that they had recently considered moving house to another area, but decided not to as they wished to remain at this practice.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation or treatment room. There were privacy curtains for use during physical and intimate examination and a chaperone service was offered. We had some concerns relating to reception staff acting as chaperones during intimate examinations or medical procedures due to their lack of training and expertise.

We saw that staff had received training on bullying and harassment, code of conduct and equal opportunities. Staff we spoke with were clear on their responsibilities to treat people according to their wishes and diversity.

We looked at the results of the 2014 GP patient survey. This is an independent survey run on behalf of NHS England. The survey results reflected that 98% of respondents said the last GP they saw or spoke to at the practice was good at treating them with care and concern. 85% of respondents said the last nurse they saw or spoke to was good at listening to them.

Care planning and involvement in decisions about care and treatment

Patients said that staff were very good at listening to them and clinical staff provided lots of information to assist them in deciding what was best.

A wide range of information about various medical conditions was accessible to patients from the practice clinicians and prominently displayed in the waiting areas. We noted that during our inspection patients readily picked up the practice information folders and browsed their contents.

We saw that the GPs at the practice had recently undertaken training called advanced care planning for general practitioners. This training had been provided by the local Hospice. This had enabled the GPs to better support and plan patients who were nearing the end of their life.

The 2014 GP patient survey reported that 92% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 77% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and the comment cards we received showed us that patients found staff supportive and compassionate. We were told by patients that because staff had been at the practice a long time, they understood people's personal circumstances and were better able to respond to their emotional needs.

Notices in the patient waiting room and the practice website signposted people to 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.

We saw that in the staff kitchen there was a list of all recent patient deaths. Staff told us that this was helpful when speaking to relatives and others who knew the person who had died. They told us they would offer condolences and as much support as they could. Staff told us families who had suffered bereavement were called by their usual GP.

The 2014 GP patient survey reported that 99% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 85% say the last nurse they saw or spoke to at the practice was good at listening to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team had planned and implemented a service that was responsive to the needs of the local patient population. The practice actively engaged with commissioners of services, local authorities, other providers, patients and those close to them to support the provision of coordinated and integrated pathways of care that met patient's needs. The practice had explored and was involved in a variety of ways to continually improve the way they responded to people's needs. These included regular integrated neighbourhood team (INT) meetings, buddy group meetings, primary health care team meetings and meetings with community matrons and district nurses.

Patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by effective verbal and electronic communication between the clinical team members. Longer appointments could be made for patients such as those with long term conditions or who were carers. Clinical staff also conducted home visits to patients whose illness or disability meant they could not attend an appointment at the practice.

GPs we spoke to were able to demonstrate that they considered the particular needs of patients who were vulnerable such as people with long term health conditions, dementia, learning disabilities and older people. Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

We saw that the practice carried out regular checks on how it was responding to patients' medical needs. This assisted the clinicians to check that all relevant patients had been called in for a review of their health conditions and for completion of medication reviews.

Bryn Cross surgery had a reception area, a patient waiting area, four consultation rooms and a treatment room. The treatment room was designated for carrying out minor surgical procedures. There were also facilities to support the administrative needs of the practice (including a reception office, practice manager's office and a meeting room). The building was easily accessible to patients including those with a disability. The lead GP told us that the surgery had grown over the last 17 years and that they had been proactive in becoming a training practice. Plans were in place to further increase the size of the practice and provide improved facilities for patients.

The practice had an effective and active PPG and we saw that information about the PPG was displayed around the reception area. A section of the practice website provided information about the PPG and how it responded to patient needs and suggestions. We looked at the 2013/14 patient questionnaire action plan and saw it contained a well-documented matrix for addressing the issues raised by patients. These included parking arrangements, customer care training, appointments and privacy. Each issue had a proposed solution or action against it and patients were clear on what action was to be taken. We saw that the PPG was involved in a wider locality forum so that issues and best practice could be discussed with similar groups in the area. The practice had organised training inputs for members of the PPG including first aid courses and diabetes awareness.

Tackling inequity and promoting equality

The practice had taken steps to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. We saw that information displayed at the practice had also been provided in easy read format, making it more accessible for people with learning disabilities. Annual reviews were scheduled for people who had differing needs, reception staff each took responsibility for ensuring patients had responded to their invitation request.

The practice had a population of gypsy travellers living in the locality. We saw that they had been registered as temporary patients and that the practice had encouraged them to attend for health checks when possible. The practice manager told us that he knew these temporary residents very well and attempted to keep their records as complete as possible. We also saw that asylum seekers were registered at the practice and seen by clinicians so as

Are services responsive to people's needs?

(for example, to feedback?)

to meet their needs. Their details were recorded on a separate register and translation facilities were available to all staff should they be required. There were good communication links with the local homeless and vulnerable people service, who were able to provide information on the medical requirements of this group of people.

Access to the service

There were no negative comments about being able to access the services at the practice. We also looked the results of the 2014 GP survey 97% of respondents found the receptionists at the practice helpful, 99% of respondents said the last appointment they got was convenient, 95% were able to get an appointment to see or speak to someone the last time they tried and 98% of respondents described their overall experience of this surgery as good.

The opening hours and surgery times at the practice were prominently displayed in the reception area, on the practice website and were also contained in the practice information leaflet readily available to patients in the reception area. The practice was open every weekday 8.30am to 6.30pm except for Wednesdays when they closed at lunchtime. Extended hours were operated on Mondays to provide service for people who could not generally attend during office hours. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances

GP appointments were provided on a traffic light system, yellow was for appointments that could be made up to seven days in advance, orange for on the day bookings and red for emergency appointments. We saw that this system operated very effectively and patients spoke highly about access to appointments and chosen GP. Patients accessed appointments by telephone, in person or via the practice website. Two female and two male GPs were available at the practice and every effort was made to ensure that a GP of either sex was available every day. We saw that there were rotas and appointment planning in place to facilitate this.

The practice manager had introduced an electronic messaging system to aid communication between reception staff and clinicians. We saw that this worked very effectively in ensuring that patients received a prompt and effective service. We saw how the reception staff were effective in triaging patients, a clear flowchart had been developed by the practice manager, and we saw that this worked particularly well. We talked to the lead GP and the practice manager about the triage system and were told that it had been so effective that other practices within the area had utilised it and it had been held up as best practice by the CCG.

The practice operated an effective referral system to secondary care (hospitals). This was a choose and book system where the GP used the electronic messaging system to prompt reception staff to create an appropriate appointment based on patient choice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system both within the practice information book and leaflets as well as the practice website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. One of the patients spoken with had a minor complaint to make, but had never felt strong enough to air their views. They knew the process for doing so had they wished to.

We looked at several complaints received in the last twelve months. In line with good practice all complaints and concerns were recorded and investigated and the record detailed the outcome of the investigation and how this was communicated to the person making the complaint. We established from reception staff that they were confident with dealing with minor complaints. However they were often not recorded and when they were, they were recorded only on patient notes, making them difficult to review.

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

There was a well-established leadership structure with clear allocation of responsibilities amongst the GP's and the practice team. We saw evidence that showed the GP and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

We spoke to the lead GP about the vision and values of the practice, They were clear that communication between GPs, clinical staff, management, reception staff, patients and partner groups was essential. This was displayed in the regular meetings both formal and informal that took place. The culture at the practice was one that was open and fair. Discussion with members of the practice team and patients demonstrated this perception of the practice was widely shared.

We saw that the practice had a documented statement of purpose which included their mission statement 'to improve the health and wellbeing of those we care for. Putting patient's needs at the heart of everything we do.' The practice vision was to; 'work in partnership with our patients and staff to provide the best primary care services possible working within local and national governance, guidance and regulations.' These high level statements were on display within the practice and were reflected in the manner in which the practice was run.

Governance arrangements

There were defined lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular staff practice meetings. We looked at minutes from recent meetings and found them to be clear and well documented. We saw that topics were wide reaching and reflected the sorts of issues that we would anticipate reflecting good practice. Discussion with GPs and other members of the practice team demonstrated that a fair and open culture at the practice enabled staff to contribute to arrangements and improve the service being offered.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above the level of the average for the area. We saw that QOF data was regularly discussed at practice meetings and action plans were produced to maintain or improve outcomes.

The practice had a system in place for completing clinical audit cycles. These were quality improvement processes that sought to improve patient care and outcomes through the systematic review of patient care and the implementation of change. Clinical audits were instigated from within the practice or as part of the practice's engagement with local audits. We saw that there was a strong focus on completing clinical audits.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as environment and infection prevention. We saw that the risks were regularly discussed at team meetings and updated in a timely way.

Leadership, openness and transparency

We were shown a clear leadership structure. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Most of the team had worked together for many years and there was a very low turnover of staff. They told us that teamwork was very important and they felt as a team they were very effective in delivering high quality care.

We saw staff undertook annual appraisals. We looked at some of these and saw they were well documented and took notice of the views of the staff member in their review of performance. We discussed the potential for documented supervision meetings between appraisals as a method of evidencing staff support. The practice manager agreed that together with the open door policy and strong informal communications between staff and management, this would be a good idea.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example sickness and absence, stress, bullying and harassment and equal opportunities, which were in place to support staff. We were shown the staff induction

Are services well-led?

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

handbook that was available to all staff which included sections on equality and compassionate leave. Staff we spoke with knew where to find these policies if they required them for review.

Staff we spoke to were very complimentary about the lead GP's management style. We were told that support for learning, development and peer review was very good. Staff told us that the GPs encouraged other members of staff to contribute to the way the practice was run and that any suggestions for meeting agenda items could be added to a list in the staff kitchen. Staff felt empowered to make suggestions and where appropriate make challenges to management decisions.

Practice seeks and acts on feedback from its patients, the 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 2014 GP patient survey and the survey conducted by the practice in October 2013. Both surveys reflected high levels of satisfaction with the care, treatment and services provided at Bryn Cross Surgery. The National GP survey showed particularly high levels of satisfaction from patients with all respondents rating the service as excellent or good and none rating any lower.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG contained representatives from various population groups. We spoke to a member of the PPG who said that it worked effectively and was an excellent way of patients influencing the way the practice was run.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they had no problems accessing training and were actively encouraged to develop their skills. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. They said that the excellent teamwork was instrumental in this.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and appraisal. Staff told us that the practice was very supportive of them accessing training relevant to their role and personal development.

The practice was a GP training practice. Currently one registrar was working at the practice and another two were attached to the practice as part of their training period. We saw that the practice ensured that protected learning time was made available and regular mentoring and peer reviews took place.

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. Clinical staff attended meetings with other healthcare professionals to discuss and learn about new procedures, best practice and clinical developments.

The practice had completed reviews of significant events and other incidents and shared the outcomes of these with staff during meetings to ensure outcomes for patients improved. Where appropriate significant events had been notified to the CCG in order that learning on a wider area base could be achieved.

We saw that the practice had undertaken initiatives and in order to test them they had completed pilots to see if the initiatives were effective. One of these was a pharmacy pilot which attempted to reduce the amount of wasted medicines by encouraging pharmacies to contact patients to confirm medication requirements. This had the added benefit of increasing patient safety as unused medicines were not left in homes as potential dangers.