Lingsbrook GP Practice

Quality Report

Weston Favell Centre
Billingbrook Road
Northampton, NN3 8DW
Tel: 01604 589897
Website:www.lingsbrookpractice.nhs.uk

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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 inspected Lings Brook GP Practice on 21 October 2014. This was a comprehensive inspection. The practice was selected because we had not inspected it previously.

Lings Brook GP Practice is managed by Virgin Care Coventry LLP under an Alternative Provider medical Services (APMS) contract. The contract also covers Kings Heath GP Practice but this location is separately registered with CQC and was not visited as part of this inspection.

The overall rating for this practice is 'Good'.

Our key findings were as follows:

- The practice met the needs of its population by working closely with other stakeholders to ensure that patients' health and well-being needs were met.
- Although the practice had been challenged in providing access to GPs due to staff turnover, they had taken steps to improve that access and continuously reviewed how the changes they had made were impacting upon patients.

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

The provider should:

- ensure that the responsibilities held by the clinical lead are shared with the recently recruited salaried GPs and practice nurse.
- actively promote the availability of health interventions such as seasonal flu vaccinations in the practice and on the website.

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 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.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for caring. 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 responsive. 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. 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. although patients reported dissatisfaction with the appointments system the practice kept this under constant review and implemented changes designed to improve access.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. Staff were clear about the vision

Summary of findings

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 regular governance meeting had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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 the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check 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 population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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 offer continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflects the needs for this age group.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had planned annual health checks for people with learning disabilities but due to staffing shortages had fallen behind with them. Vacancies had now been filled and the reviews ideintified as a priority.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had sign-posted vulnerable patients to various support groups.. 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 and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia.

The practice had sign-posted patients experiencing poor mental health to various support groups. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training on how to care for people with mental health needs and dementia

Summary of findings

What people who use the service say

Patients completed CQC comment cards to provide us with feedback on the practice. We received 12 completed cards, ten of which expressed dissatisfaction with the appointment system. The practice had experienced a very high number of patients not attending pre-booked appointments which meant that patients who requested same day appointments had long wait times. In most of the comment cards we received patients praised reception staff who they said treated them with dignity and respect.

We also spoke with two patients on the day of our inspection (the triage system meant that there were low numbers of patients attending the practice in person). Both told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

In the annual patient survey over 70% of patients said they felt involved in their care and had been treated with respect and dignity by their GP.

Areas for improvement

Action the service SHOULD take to improve

- ensure that the responsibilities held by the clinical lead are shared with the recently recruited salaried GPs and practice nurse.
- actively promote the availability of health interventions such as seasonal flu vaccinations in the practice and on the website.

Lingsbrook GP Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP, a further CQC inspector and a CQC Inspection Manager.

Background to Lingsbrook GP Practice

Lings Brook GP Practice is situated on the Eastern side of Northampton in a primary care centre which is shared with three other GP practices. The practice has a patient list of 4100, 70% of which are aged between 19 and 75 years and just 2.5% over 75 years. The area is identified as being in social deprivation. There is a GP clinical lead (who works across both Lings Brook and its partner practice in the Kings Heath area of Northampton); two salaried GPs; an advanced practitioner nurse (who is based in Kings Heath and covering the practice nurse vacancy); a practice manager, an assistant practice manager and five non-clinical staff including receptionists and administrators. The registered manager is a regional manager for Virgin Care Coventry LLP. There are two female GPs (including the clinical lead) and one male GP.

As part of this inspection we visited Lings Brook GP Practice, Weston Favell Centre, Billingbrook Road, Northampton NN3 8DW.

The contract held by Virgin Care Coventry LLP for the services provided at Lings Brook GP Practice is an APMS contract. The contract also covers Kings Heath GP Practice which is registered separately with CQC.

The practice has opted out of providing an out of hours service to their patients. Patients are directed NHS 111 when the practice is closed.

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.

This provider had not been inspected before and that was why we included it.

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

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Detailed findings

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 inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We spoke with the local Clinical Commissioning Group (CCG), the Local Medical Committee (LMC) and NHS England. We carried out an announced inspection on 21 October 2014. During our visit we spoke with a range of staff, including GPs, reception staff, administration staff, receptionists, practice managers, the registered manager and the Virgin Care Regional Operations Manager. We spoke with patients who used the service. We observed how patients and family members were dealt with and collected comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example in March 2014 when providing a patient with a dressing the practice nurse had noted that the patient was in receipt of a blood thinning medicine but had not been attending appointments at the anti-coagulation clinic to monitor the length of time it took for their blood to clot .This was brought to the attention of the GP as all patients in receipt of this medicine need to have this monitoring on a regular basis.

Following this incident all patients with a repeat prescription for this blood thinning medication were identified; any who had not attended a review in the previous three months were referred to the anti-coagulation clinic for a review and requested to book an appointment to see a GP within one week. Some patients' repeat prescriptions were cancelled to encourage their attendance at an appointment and they were followed up to ensure those appointments were made.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last three years. This showed the practice had managed these consistently over time and so could evidence 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. Records were kept of significant events that had occurred during the last year and these were made available to us. A slot for significant events was on the practice clinical governance meeting agenda and a dedicated meeting occurred monthly to review actions from past significant events and complaints. There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. As the meetings covered both Lings Brook and its sister practice at Kings Heath, the learning from events and complaints was shared across both practices. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at these meetings and the practice meetings and felt encouraged to do so.

We saw incident forms were available on the practice intranet. Once completed these were sent to the practice manager who showed us the system he used to oversee these were managed and monitored. We tracked two incidents and saw records were completed in a comprehensive and timely manner. Evidence of action taken as a result of a prescribing error was shown to us. A patient had been prescribed the incorrect dosage of a pain relieving medication which had resulted in them being admitted to hospital. We saw evidence that immediate action was taken in the form of an investigation. The GP concerned attended extra training and was placed under the supervision of the clinical lead who checked all controlled drugs prescribed by that GP. The practice had met with the patient and their partner and provided them with a named GP.

National patient safety alerts were disseminated by email to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for. They also told us alerts were discussed at clinical governance meetings to ensure all were aware of any relevant to the practice and where action needed to be taken. We saw from the minutes of these meetings that staff were also encouraged to access the Department of Health's Central Alerting System (CAS) and specific alerts were highlighted.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. The practice's adult safeguarding policy and procedure was detailed and comprehensive although we noted that it had recently been produced and was yet to be signed by staff to confirm they had read and understood it. The lead GP for safeguarding told us that the child safeguarding policy was under development. There was a clear reporting structure in place. If a safeguarding concern was raised by another staff member, a 'flag' was automatically raised on the safeguarding lead's computer screen.

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children who had been trained and could demonstrate they had the necessary

training to enable them to fulfil this role. All staff we spoke to were aware of who this lead was and who to speak to in the practice if they had a safeguarding concern. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Clinical staff (with the exception of two salaried GPs who had joined the practice two months previously) had been trained to Level 3 which provided them with a wide knowledge of child protection issues. We saw evidence that this training was planned for the new GPs in the near future. Administrative staff had been trained to Level 1. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, those patients with caring responsibilities, patients with a diagnosis of dementia and patients with learning disabilities.

A chaperone policy was in place and visible in consulting rooms. Reception staff had undertaken training and understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system (System One) which collated all communications about the patient including scanned copies of communications from hospitals. The practice operated a peer review system in which patient records were checked weekly and any issues discussed at clinical governance meetings. This was confirmed in the minutes of those meetings.

The practice had identified those children who were looked after, designated as 'in need' or on a child protection plan. Those children were flagged on the electronic case management system. The safeguarding lead led on child protection issues and all cases and updates were referred to her. We saw that individual cases and actions were discussed at the practice clinical governance meetings. At practice meetings, reception and administrative staff were regularly reminded of the processes relating to their responsibilities in relation to child protection tasks.

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 medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

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.

Vaccines were administered by a member of the nursing staff from the sister practice who was qualified as an independent prescriber and was covering the nurse role at Lings Brook. She received regular supervision and support in her role as well as updating in the specific clinical areas of expertise for which she prescribed.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patient's repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. A medicines safety audit action plan was generated by Virgin Care once the data had been input and appropriate actions identified based on the results. This was monitored by the regional management team to ensure appropriate actions were taken within specified time frames.

Cleanliness & Infection Control

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

Good

Are services safe?

The practice had a lead for infection control. All staff received induction training about infection control specific to their role and thereafter annual updates. We saw evidence the lead had carried out an audit during the last four months and that any improvements identified for action were completed on time.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Hand hygiene techniques signage was displayed in toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales and the pulse oximeter had been tested in June 2014.

Staffing & Recruitment

We looked at recruitment records for two staff, one of whom had joined the practice in the previous two months. Both files 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 via the Disclosure and Barring Service. 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. Staff shortages were managed between Lings Brook and its sister practice on the other side of Northampton. One sickness absence was being covered by a member of staff from the other practice on the day of our inspection. That member of staff told us they would be covering the post indefinitely to ensure that staffing levels remained appropriate to meet patients needs. The practice had recently recruited a new practice nurse following the sudden departure of the previous post holder who had not given notice. Whilst they were waiting for the newly recruited nurse to take up post, the Advanced Nurse Practitioner (ANP) from the sister practice was helping to cover nursing duties. Following a significant period in which the GP posts had been staffed by locums, the practice had recently recruited two salaried GPs who had been in post approximately two months on the day of our inspection. They were being supported and managed by the clinical lead from the sister practice whilst they settled into post. The practice was trying to recruit a further GP on a part-time contract.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

There were systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy and mandatory audits were completed each month. All checks and audits were reported to Virgin Care on a monthly basis and reviewed during the monthly clinical governance meetings which covered both Lings Brook and its sister practice.

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that risks were discussed at clinical governance meetings and within team meetings. For example, learning following an incident relating to urgent test results not being passed to a GP in a timely way had been shared with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. Reception staff told us how they would escalate concerns over the wellbeing of patients to the GP on duty. If there was no GP

Good

Are services safe?

available they would refer their concerns to one of the GPs at the other practices which are based within the same building. We saw evidence of discussions relating to the identification by the GP of the need for a patient to have a mental health assessment and how this was to be managed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing 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). All staff asked knew the location of this equipment. Responsibility for checking this equipment lay with one of the other four practices housed in the primary care centre in which the practice was located. In the notes of the practice's clinical governance meetings, we saw that medical emergencies concerning patients were regularly discussed; appropriate learning had been identified and had taken place.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. Should evacuation of the practice be necessary, the contingency was for patients and staff to be transferred to the sister practice across the other side of Northampton. Patients would be able to access the Doctor First appointment system in the same way as the telephone number for that system was the same for both practices.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw the practice risk log which was overseen by the regional management team for Virgin Care. The risk posed by a staffing shortage at the practice was recorded there and and the mitigating actions that had been put in place to manage this, involving staff working across both Lings Brook and its sister practice as well as recruitment to vacancies were detailed on the log.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs that staff completed thorough assessments of patients' needs and these were reviewed when appropriate.

The Advanced Practitioner Nurse led in the specialist clinical areas of COPD and asthma and the practice staff supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The practice manager told us that new best practice guidelines were reviewed from time to time at the practice clinical governance meetings. Our review of the meeting minutes confirmed this happened.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race did not impact upon this decision-making.

Management, monitoring and improving outcomes for people

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

The practice showed us two clinical audits that had been undertaken in the last year. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. By limiting the review period for warfarin prescribing to three months the practice had improve concordance with regular monitoring guidelines and had improved patient safety for those prescribed warfarin. The practice had undertaken to maintain the three month review period for warfarin and the re-audit records at six monthly intervals.

Due to recent staffing changes the practice was behind with evidence gathering to illustrate their performance against local targets for specific illnesses and conditions. This was referenced in clinical governance meetings and all relevant staff encouraged to fulfil their assigned roles in the process to ensure that evidence was gathered appropriately in order to meet 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 upon the outcomes being achieved and areas where this could be improved. The clinical decision making by the two salaried GPs who had taken up post approximately two months prior to our inspection were still subject to review by the clinical lead. It was anticipated that this would decrease at the end of their three month probation periods.

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 alerts when the GP went to prescribe medicines.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The newly recruited practice nurse was not in post on the day of our inspection. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive

Good

Are services effective?

(for example, treatment is effective)

in providing training and funding for relevant courses. For example one receptionist who was working under an apprenticeship programme had asked to be trained as a phlebotomist. This had been agreed and the training was planned for February 2015. In addition, the practice had offered to train her as a healthcare assistant once her apprenticeship has ended and this had been accepted.

Practice nurse duties were clear and the practice was able to demonstrate the practice nurse was trained to fulfil these duties. On the day of our inspection the Advanced Practitioner Nurse from the Kings Heath practice who was covering some of the practice nurse duties at Lings Brook duties was working at the sister practice.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers and the 111 service were received both electronically and by post. The practice had a policy and guidance outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There had been one within the last year in which results had not been followed up quickly enough following telephone notification of results by the laboratory when the GP was not at the practice. This had been investigated and GPs instructed to redirect their tasks, pathology results and notifications to a colleague when on leave.

The practice used the CCG's pathfinder system in order to make appropriate referrals into other services where needed. We saw evidence in minutes of the clinical governance meetings that the practice worked closely with other professionals such as community health services, the local safeguarding team, child protection, the mental health crisis team and the police to ensure that patients were supported for those needs that went beyond what the practice was able to provide.

Information Sharing

The practice used several electronic systems to communicate with other providers. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

The practice had systems in place to provide staff with the information they needed. An electronic patient record, System One, was used by all staff 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.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling them. Clinical staff we spoke to 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 was an issue best interests meetings were held, involving clinicians, the patient and their relatives and carers.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. At the time of our inspection approximately 50% of patients with learning disabilities had received their annual review The practice had identified this as a priority and it was reviewed in clinical governance meetings. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. Clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

At the time of our inspection minor operations were not being carried out at the practice. However, Virgin Care policies on obtaining consent were available.

Health Promotion & Prevention

The information provided by the local public health authority and the CCG about the needs of the practice population as identified by the Joint Strategic Needs Assessment (JSNA) was used by the practice to determine

Good

Are services effective?

(for example, treatment is effective)

the profile of its patient groups. 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. The clinical lead met monthly with the CCG.

It was practice policy to offer all new patients registering with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic weight management and smoking cessation advice to smokers as well as flu vaccinations.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a log of all patients with learning disabilities aimed to offer all of them an annual physical health check . At the time of our inspection the practice was behind with these checks and those for patients over 75 due to the recent staff instability and difficulties in recruiting GPs. As two salaried GPs were now in place the practice planned to increase the number of checks taking place. Patients with diagnosis of COPD, asthma, diabetes and mental health needs were offered at least annual health checks.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. However, on the day of our inspection there were no posters displayed in the waiting room to encourage patients to have their seasonal flu vaccination and neither was it promoted on the practice website.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was drawn from information from the national patient survey as the practice patient survey incorporated both Lings Brook and Kings Heath practices meaning evidence for Lings Brook could not be separated. The evidence from this source showed a significant number of patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 74% patients rated the practice as good or very good. The practice satisfaction scores on consultations with doctors and nurses showed 71% of practice respondents said the GP was good at listening to them and 73% said the GP gave them enough time.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 12 completed cards, ten of which expressed dissatisfaction with the appointment system. The practice had experienced a very high number of patients not attending pre-booked appointments which meant that patients who requested same day appointments had long wait times. The practice had tried to address this problem by introducing a triage system in which patients were given a slot in which a GP would telephone them to determine whether they needed to be seen. In the comment cards we received patients praised reception staff who they said treated them with dignity and respect. We also spoke with two patients on the day of our inspection (the triage system meant that there were low numbers of patients attending the practice in person). Both 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. 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 room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The reception area is shared by four GP practices who are all located in the same building. In response to the obvious problems posed by the environment, a system had been introduced to allow only one patient at a time to approach the reception desk and a demarcation area was indicated by tape on the floor. This was not sufficient to prevent patients overhearing potentially private conversations between patients and reception staff. However, reception staff told us they would offer to speak with patients in a private office if needed in order to enable confidentiality to be maintained.

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

The practice had a zero tolerance policy on abuse behaviour towards practice staff. Receptionists told us referring to this had helped them diffuse potentially difficult situations although they also said that the policy was not always strictly adhered to, depending on the individual circumstances of the patient. We saw minutes of a practice meeting which described how the practice had called the police to remove a patient who had become aggressive when attending an appointment with their child. The practice had attempted to calm the patient before resorting to that action.

We spoke with a patient who had problems with substance misuse. They told us that they felt that they were treated with dignity and respect and their needs were fully met by the practice in a timely way.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 71% of practice respondents said the GP involved them in care.

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

Good

Are services caring?

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.

Staff told us that translation services were available for patients who did not have English as a first language. Reception staff told us they would inform patients of this service when needed. They also told us that they would not routinely rely upon relatives to translate unless the patient had arrived with an urgent problem and could not wait for a translator.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke to on the day of our inspection and most of the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room signposted people to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Staff told us families who had suffered bereavement were signposted to support services.

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 people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice was aware of the ethnic make up of the patient population and had translation services in place for those patients for whom English was not their first language. There were both male and female GPs available to ensure patients were able to access appointments with a GP of the gender with which they felt comfortable.

There had been significant turnover of staff during the last year. The practice had tried to ensure continuity of care and accessibility to appointments by using regular locum GPs as well as cover of the nursing role by the Advanced Practitioner Nurse from Lings Brook's sister practice, Kings Heath. Two salaried GPs had been appointed and started work at the practice approximately two months prior to the date of our inspection. A practice nurse had also been recruited and was due to take up her post approximately two weeks after our inspection. Longer appointments were available for people who needed them and those with long term conditions. Patients aged under five or 75 and over were prioritised for appointments with the GPs. Home visits were made to two local care homes regularly and to those patients who needed one.

The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment. The system for recording information received from the out of hours provider and secondary care providers such as the local hospital was managed effectively by the reception team. They ensured that GPs were informed outcomes for patients accessing those services by the use of task notes and flags on the practice's computerised records system.

Tackle inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. A large number of the practice population were of non-British origin and the practice ensured that those patients were able to access translation facilities. One patient we spoke with attended their appointment with their key worker and told us that they felt their individual needs were well met by Lings Brook.

The premises had been adapted to meet the needs of people with disabilities by the landlord. The building was accessed by automatically opening doors and the reception area did not provide any obstacles to wheelchair users.

Access to the service

Due to the high number of patients not attending pre-booked appointments the practice had introduced a triage system called Doctor First in which patients call the practice to request a call back from a doctor. Patients were free to cancel appointments up to one hour before their allotted time before it was counted as a 'Did Not Attend (DNA). This had resolved the issue of patients waiting for long periods in the surgery for their appointments. However, the comment cards we received as well as information on NHS Choices website showed that those patients who responded were unhappy with this system and would prefer to see a GP rather than speak to one on the telephone. The practice were reviewing the feedback from patients on the appointment system. They had concluded that most patients who were working were happy with the system as it meant they did not need to take time off work if a diagnosis could be made over the telephone. At the time of our inspection the practice were considering introducing a hybrid system of telephone appointments and GP consultations in order to meet the needs of all groups of patients and their preferences. It was clear to the inspection team that Lings Brook practice was working hard to ensure that the maximum numbers of patients were able to access a GP.

The practice offered a significant range of extended opening times which were particularly useful to patients with work commitments. On weekdays it was open from 8.00 am (7.00 am on Wednesdays) until 6.30 pm (7.30 pm on Mondays). Between 9.00 am to 12.00 pm on Saturdays patients from Lings Brook were able to make appointments at the sister practice in Kings Heath. Patients aged under five or 75 and over were prioritised for appointments with the GPs.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and

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Are services responsive to people's needs?

(for example, to feedback?)

how to book appointments through the website. There were also 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. Information on the out-of-hours service was provided to patients. The practice should note that the closing time for Mondays is given as two different times on the home page of its website.

One patient we spoke with was a temporary patient who had registered with the practice that day. They had come to the surgery at 8.30 am and been registered then returned at 3.30 pm on the same day for their appointment to see the GP. They were given a prescription as required.

The practice also provided services to patients who lived at a local holiday caravan park. As the park is not residential patients are registered care of the practice address for the one month of the year in which they have to vacate the park. This ensured that patients were not de-registered by other local services.

The practice was situated on the ground floor of the building with all services for patients on the that floor.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

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. There was a designated responsible person who handled all complaints in the practice.

We saw that detailed information was available to help patients understand the complaints system on the practice website. Brief information on making a complaint was also included in the practice leaflet.

We looked at four complaints received in the last twelve months and found they were investigated thoroughly and in a timely way. The patients were informed of the outcome of their complaints and reviews of practice identified with measures established to monitor improvements.

Complaints information was reviewed by the a dashboard submitted to Virgin Care on a monthly basis. Themes and trends were identified and the lessons learnt discussed at clinical governance meetings. As these meetings involved staff from both Lings Brook and its sister practice, learning from complaints at both practices was shared.

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

Under the Virgin Care brand the practice's mission statement stated its intent to give patients high quality care and easy and convenient access to healthcare. This statement was included on the practice website which also included the core values and principles of being patient-centred, ethical, passionate and providing quality and team work.

We spoke with seven members of staff who understood the vision and values and knew what their responsibilities were in relation to these. Our discussions with those staff and our observations of their patient interactions demonstrated that they embodied those values in their work.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at the policies and the records of staff having read and understood them and found these to be up to date. Policies were produced by Virgin Care and updated regularly and appropriately.

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. We saw that QF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. Due to the staffing instability of the previous few months it had been identified at the most recent of these meetings that the practice was behind with this year's QOF targets and actions to improve performance identified. This included receptionists being allocated QOF responsibilities. At the time of our inspection the reception staff had been allocated those responsibilities and were undertaking the relevant tasks.

The clinical lead told us that she peer reviewed the work of any locum GPs and, more recently, the two newly appointed salaried GPs until they complete their probationary periods with the practice. Our review of clinical governance meeting minutes found that outcomes of the peer review of patient notes were discussed at those meetings.

The practice had carried out one completed clinical audit on patients receiving Warfarin to check how often they had attended reviews at the anti-coagulation clinic. Where patients had not attended regularly repeat prescribing practices were reviewed in order to ensure those patients did attend reviews. Other audits in progress included duration of contraception injections and the use of the post natal check template to ensure patients were advised on contraception after childbirth.

The practice had robust arrangements for identifying, recording and managing risks. The registered manager showed us their risk log which addressed a wide range of potential issues, such as the impact of difficulties in recruiting GPs in the local area. We saw that risk was regularly discussed at team meetings and the log updated in a timely way.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example the clinical lead was the lead for safeguarding and a number of other lead roles. Due to the difficulties in recruiting permanent staff the clinical lead had taken on a significant amount of clinical responsibilities in addition to her own role in Lings Brook's sister practice. We were concerned that there was an overload of responsibility upon her but were assured by the registered manager that this would be reduced upon the newly appointed salaried GPs successful completion of their three month probationary period in the month following our inspection. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that they felt valued and well supported by the management structure in the practice which included the deputy practice manager, the practice manager and the two regional managers, one of whom was the registered manager. All staff said they knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly, usually monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that protected learning time meetings had been held in May and September 2014.

Are services well-led?

Good

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

The practice followed the human resource policies and procedures supplied by Virgin Care. We saw that there were a number of policies in place to support staff. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through a patient survey, a token system and a comment box. We looked at the results of the patient survey for 2013-14 and saw most responding patients were concerned about the difficulties in getting an appointment. Patient comments related to the number of patients not attending pre-booked appointments (DNA) causing a delay in others getting appointments, not being able to see the same doctor consistently and difficulty in getting through on the phone to make an appointment. The practice responses included recruiting salaried GPs to the practice, implementing the Doctor First system of triaging appointments and setting up an online booking system for appointments. The practice had responded to the patient feedback and, at the time of our inspection, these measures were well underway and being reviewed for impact upon the service provided to patients at Lings Brook.

The practice told us they had tried to set up a patient participation group (PPG) but had so far been unsuccessful. Only one patient at Lings Brook had shown interest in being on the PPG and so that patient was encouraged to attend the meetings of the PPG at Lings Brook's sister practice to ensure their views were captured. The practice website is misleading as it does suggest there is a PPG dedicated to Lings Brook. The practice should ensure that the website is updated to reflect the current situation regarding the lack of a PPG at Lings Brook.

We did not see feedback gathered from staff. However, we spoke with many of the staff working in the practice and each of them 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 and described the management system as 'open'.

Management lead through learning & improvement

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

The practice manager had attended a business management course and received investigation training. Both courses were provided by Virgin Care. He was also supported by a regional practice manager forum and met formally with his regional manager (the registered manager) once per month although in practice, the registered manager usually visited Lings Brook once per week. The clinical lead received both regional and national support though her membership of a clinical lead group which met regularly.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients. For example, a patient had been refused a prescription for repeat medication as they needed a review. The minutes of the clinical governance meeting in August show that the clinical lead reminded all staff of the correct process which meant the receptionist must consult the GP.