St George's Surgery

Quality Report

St Paul's Medical Centre
121 Swindon Road
Cheltenham
Gloucestershire
GL50 4DP
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Website: www.st-georgessurgery.co.uk

Date of inspection visit: 21 January 2015
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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at St George's Surgery on 21 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older people, children and families and young people, the working population, people in vulnerable circumstances and with long term conditions and people with mental health problems.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available but not promoted clearly in the waiting areas.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

Summary of findings

- The practice provided general health advice including a sexual health clinic for young people. In addition a drop in clinic was available to young people registered with the practice where they could receive health advice or treatment including sexual health services.
- Patients were given a Gloucester Clinical Commissioning Group (CCG) 'Online Care Plan' card which they could share with services such as A&E to enable them to access their online care plan.
- The practice employed a practice nurse with a responsibility for three care/nursing homes who provides an annual health review of all residents registered with the practice in addition to reviews individual residents who may require for long term condition management.
- The Practice employed a Care Coordinator to manage the 226 patients on its most vulnerable patients list.

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

Importantly the provider should;

- Review how significant events and complaints are logged and ensure evidence is kept of how learning is made available to all staff in the practice.
- Review the system for storing and organising staff files, including recruitment, induction and training information.
- Ensure nursing staff receive formal training in regard of the Mental Capacity Act 2005
- Review how patient records are documented if the computer based record system fails.
- Ensure a log is maintained of completed audits to aid easier retrieval and monitoring of completed audit cycles.
- Review how complaints are logged and ensure the complaints policy is reviewed and made more accessible to patients.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data from our information management pack showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. 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 that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice employed a practice nurse with a responsibility for three care/nursing homes where older people at the practice are registered. This service had been running for one year and offered care to meet the needs of the older patients in its population. Each of the three care homes were allocated to a named GP. The practice nurse provides an annual health review of all residents registered with the practice in addition to reviews individual residents may require for long term condition management. The Practice Nurse also visited housebound patients annually to administer flu vaccinations.

People with long term conditions

Good

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

Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly GP and nurse led clinics were available to patients diagnosed with diabetes. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up

children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Child immunisations were checked regularly by the nursing team. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments. We saw routine audits were carried out by the practice to highlight non-attenders for immunisations and other appointments.

Working age people (including those recently retired and students)

Good

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

The practice offered extended hours on Tuesday and Friday mornings with appointments available from 7:00 am until 8:30 am and up until 7:00 pm on one day each week. GP led hormone replacement (HRT) appointments are available. Flu vaccination clinics were provided on two Saturdays in October to increase availability to patients who worked.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable

Summary of findings

patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice held a learning disability register. Patients were invited to the practice for annual health checks through a standard letter offering a thirty minute appointment with a practice nurse followed up with a consultation with a GP. (It offered longer appointments for patients with a learning disability which incorporated annual health checks for other conditions such as heart disease).

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and SANE. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

A weekly Mental Health triage worker clinic was held at the practice for those patients who may benefit from more specialist care.

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What people who use the service say

We spoke with 10 patients visiting the practice and two members of the patient participation group during our inspection. We received 28 comment cards from patients who visited the practice and saw the results of the most recent patient participation group survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice. 92% of patients describe their overall experience of this surgery as good during the 2014 GP patient survey.

All of the comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving compassionate care and treatment, about seeing the same GP or nurse at most visits and about being treated with respect and consideration. Comments from carers also spoke positively about the support they received in regard of their caring role and the support the care coordinator provided. Comments about the reception team were similarly positive.

We heard and saw how most patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. The most recent 2014 GP survey showed 88% of patients found it easy to get through to the practice and 95% of patients found the appointment they were offered was convenient for them.

Patients also told us they used the practices online booking systems to make appointments, 88% describe their experience of making an appointment as good. Others told us about the practices triage system and how GPs called them back to identify what was the best appointment for them.

Patients told us their privacy and dignity was respected at all times both during consultations and in the reception and waiting areas. They told us they found the reception area was generally private enough for most discussions they needed to make. 90% of patients said they found the receptionists at this practice helpful. Patients told us about GPs providing extra support to themselves and carers during times of bereavement. Many patients had been attending the practice for over 15 years and told us about how the practice had evolved and how they were always treated well. The GP survey showed 88% of patients said the last GP they saw or spoke with was good at giving them enough time and 97% stated they had confidence and trust in the last GP they saw or spoke with.

Patients told us the practice always appeared clean and tidy and the practice had appropriate security measures for extended hours appointments. Online repeat prescription facilities had been added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. 92% of patients described their overall experience of this practice as good.

Areas for improvement

Action the service SHOULD take to improve

The provider should;

- Review how significant events are logged and ensure evidence is kept of how learning is made available to all staff in the practice.
- Review the system for storing and organising staff files, including recruitment, induction and training information.
- Ensure nursing staff receive formal training in regard of the Mental Capacity Act 2005
- Review how patient records are recorded if the computer based record system fails.
- Ensure a log is maintained of completed audits to aid easier retrieval and for monitoring of completed audit cycles.
- Review how complaints are logged and ensure the complaints policy is reviewed and made more accessible to patients.

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Outstanding practice

We saw areas of outstanding practice:

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- Patients were given a Gloucester Clinical Commissioning Group (CCG) 'Online Care Plan' card which they could share with services such as A&E to enable them to access their online care plan.
- The practice employed a practice nurse with a responsibility for three care/nursing homes who provides an annual health review of all residents registered with the practice in addition to reviews individual residents may require for long term condition management.
- The Practice employed a Care Coordinator to manage the care plans and co-ordinate care for the 226 patients on its most vulnerable patients list.

St George's Surgery

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 CQC inspector and other specialists including, a practice manager and a practice nurse.

Background to St George's Surgery

St, George's Surgery, St Paul's Medical Centre, 121 Swindon Road, Cheltenham, Gloucestershire. GL50 4DP is one of five GP practices located in St Paul's Medical Centre close to the centre of Cheltenham. The Health Centre buildings were owned by all five practices. St George's Surgery has approximately 10,200 patients registered with the practice with a catchment area which includes Cheltenham and the surrounding villages. There are six GPs employed by the practice, two are female and four are male, the hours contracted by GPs are equal to 5.1 whole time equivalent employees. The practice is a registered training practice there is currently a female registrar GP completing their training. Additionally there are four nurses employed by the practice equal to 3.1 whole time equivalent employees, and a health care assistant is also employed.

The practice population is predominantly White British with an age distribution largely matching the national average profile; with slightly more male and female patients in the 25 to 34 age categories. The average male and female life expectancy for the practice is 79.2 and 83.5 years respectively. The patients come from a range of income categories with an average for the practice being in the fifth less deprived category. One being the most deprived and ten being the least deprived. About 11% of patients are over the age of 75 years and about 16% under the age of 15 years. Over 88% of patients said they would recommend the practice at the last National GP patient survey.

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

The practice has a General Medical Services (GMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by South West Ambulance Service Foundation Trust (SWASFT) and patients are directed to this service by the practice during out of hours.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was

planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Gloucestershire Clinical Commissioning Group and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 21 January 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included six GPs, two practice nurses, the care co-ordinator, the practice manager, administration manager and six administrative and reception staff. We spoke with 10 patients visiting the practice during our inspection, two members of the patient participation group and received comment cards from a further 28 patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, lost test results for patients and incorrect patients name recorded on message for a GP to call a patient back.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Staff we spoke with were aware of the significant event reporting process and how they would verbally raise concerns within the practice. All staff we spoke with felt able to raise any concern. Staff knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice meeting agenda and were usually attended by the GPs, the practice manager and a practice nurse. Recent significant events were discussed and we were told by GPs they also reviewed actions from past significant events and complaints. There was evidence the practice had learned from these events and that the findings were shared.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked five incidents and saw records were completed. However, the events logs lacked a chronology which would have shown when actions were achieved; meeting minutes did not document what had been discussed. We saw evidence of action taken as a result of the investigations for example, reorganising the way GP and nurses pigeon holes were now organised. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed by letter of the actions taken.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training about safeguarding during the summer of 2014 We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in the practices policies, on the computer system and on notice boards.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, level three learning for GPs with safeguarding vulnerable children and similar levels of learning for vulnerable adults. All six GPs had received this level of training. All staff we spoke with were aware who had lead responsibility for safeguarding and who to speak with in the practice if they had a safeguarding concern.

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

concerns were followed up. For example, if a child failed to attend routine appointments, was losing weight or was becoming withdrawn, the GP could raise a concern for the health visitor to follow up.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. GPs we spoke with told us whenever an intimate patient examination was required patients were offered a chaperone. Patient records we were shown confirmed this.

The practice had a system in place for identifying children and young people with a high number of A&E attendances. The GPs with lead responsibility for safeguarding attended children protection case conferences and reviews and serious case reviews where appropriate. Reports were sent if staff were unable to attend. Similar systems were in place to highlight vulnerable patients and most were included on the practices 2% list of most vulnerable patients.

During our inspection the medical records system was subject to a regional system failure. We saw the practice had a business continuity process in place and actively working. The deputy practice manager was seen to verbally advise and update all administrative staff individually. GPs and nurses were notified through the practices computer memo system.

Reception staff told us they always had print-outs of appointment schedules a day in advance which included contact details for patients. We heard reception staff apologised to patients when they arrived about possible delays. We heard an elderly patient attempt to book an appointment and was asked to telephone back later that day as the booking system was not working. We spoke to the deputy practice manager who recognised this approach might mean forgetful or busy patients might not call back which might result in health conditions going undiagnosed. They immediately spoke with reception and office staff advising them to take patient details so that the practice could call them back once the system was running again and full patient details would be available for more effective triage of patient needs.

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, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw the practice was following guidance about managing common infections such as respiratory tract and urine infections. This had led to a more targeted use of antibiotic prescribing to reduce resistance to antibiotic treatments.

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

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked four anonymised patient records which confirmed that the procedure was being followed where blood thinning medicines, or those used for the treatment of acute seizures were prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed.

Good

Are services safe?

These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely in a separate code locked key cabinet. There were appropriate arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

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

The practice had a nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had carried out audits for the previous two years and that any improvements identified for action were completed on time. For example, cleaning all non-disposable privacy curtains Minutes of practice meetings for example, 9 January 2015, showed that the findings of the audits were discussed.

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

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. Waste bins were foot operated in clinical area to maintain hygiene standards.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records for the practice that confirmed regular checks were carried out in line with this policy to reduce the risk of infection to staff and patients. An independent Legionella check was made on 10 December 2014 and a certificate issued showing the practice met these hygiene standards.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Other equipment such as fire extinguishers were also serviced and tested annually in line with fire safety requirements. Fire alarms and emergency lighting were also regularly tested and serviced in line with the practices fire policy. The security alarm was also tested annually. A recent visit from the fire risk assessor highlighted the health centre did not have a current electrical wiring safety certificate. The premises manager had arranged for this to be completed with an electrician having been booked for the end of February 2015.

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms to aid less mobile patients to stand; all appeared in safe condition. Adjustable examination couches were available in two treatment rooms and all had appropriate privacy screening. There was a sluice area for the disposal of urine samples.

Staffing and recruitment

Good

Are services safe?

Records relating to staff and recruitment which we looked at were disorganised and muddled. However we were able to see they contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at employee files for the five most recent recruitments. We noted some files did not contain a contract of employment, we were told contracts of employment were not issued until the employee had been in post for three months. There was a risk of staff being unclear about their contractual duties without a contract in place.

When looking at the recruitment files we saw there was no checklist to ensure that all steps of the recruitment process had been completed. For example, criminal records history checks through the disclosure and barring service, references and application forms or Curriculum Vitae's (CV's). We were told the practice preferred to see CV's rather than use a standard application form. CV's could be found in individual files but were seen on the practice manager's email system. An induction checklist was included however; there was no indication that these had been included.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice had a policy of not using locum GPs to ensure consistency of care was maintained as much as possible.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Cleaning materials were stored in line with Control of Substances Harmful to Health (CoSHH) guidelines

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team. Other matters which affected the shared site, for example security, were discussed at Health Centre meetings which the practice attended.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. GPs and nurses gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment from the Cheltenham mental health crisis team.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked monthly.

Emergency medicines were available and staff told us they knew of their location. Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and

Good

Are services safe?

hypoglycaemia. The practice routinely held stocks of medicines for the treatment of acute pain. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this including dialling 999 to call an ambulance. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, the contact details of a heating company to call if the heating system failed. During our first visit to the practice there was a computer system failure. We saw how the practice implemented their plan and how they were able to continue to provide a service to patients as part of their plan was to print out patient lists the previous day. However we noted the practice did not have a standard form for GPs and nurses to use to record patient appointments details for the occasions when the computer system was not available.

The practice had carried out a fire safety risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Fire equipment including fire extinguishers and emergency lighting were routinely serviced and up to date, the last check had been carried out in August 2014.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The patients we spoke with told us about how GPs and nurses involved them in their care and treatment. They told us how the treatment they received helped them to get better or to maintain their health. 89% of patients involved in the national GP patient survey said the last GP they saw or spoke with was good at explaining tests and treatments to them and 87% said GPs involved them in decisions about their care.

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, in the treatment of shoulder problems and in the use of cholesterol lowering medicines.

Clinical protocols were in place and had been adapted by the practice to add value to patient care. For example diabetes protocols had sections which included relevant injection sites for patients.

The GPs told us they had lead responsibility for specialist clinical areas such as hypertension, contraception, NICE guidance, diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for example, for the management of respiratory disorders, shoulder conditions and prostate problems. Our review of the clinical meeting minutes confirmed that this happened.

The practice had completed a review of case notes for patients diagnosed with epilepsy which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks or as required by their GP according to need.

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

Management, monitoring and improving outcomes for people

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

The practice showed us nine clinical audits that had been undertaken in the last two years. About half of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, following guidance from the World Health Organisation (WHO) regarding patients who had impaired glucose tolerance in 2013 a clinical audit was carried out and patients followed up in 2014. The aim of the audit was to ensure that all patients in this category were identified and given lifestyle advice to help reduce incidences of diabetes and related cardiovascular disease. The first audit demonstrated that 17 patients were identified. The information was shared with GPs and patients were called for a medication review. Initial results showed positive outcomes for patients but further work was identified in ensuring full reviews were carried out for all patients. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Good

Are services effective?

(for example, treatment is effective)

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of a group of medicines that can help lower the level of cholesterol in the blood. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. However some audits were not repeated and so longer term benefits for patients could not be identified. Additionally a central log was not maintained of completed audits; this meant that GPs and nurses were not always aware of the audits completed by individual clinicians.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 89/9% of patients with diabetes had a blood pressure reading in the previous 12 months, and the practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease) dementia diagnosis, antibiotic prescribing and flu vaccinations. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical supervision, audits and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved particularly where there were financial incentives to do so. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that at least one audit a year should be completed by the clinical staff as part of their continuous professional development requirements.

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

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of vulnerable patients on the register to about 2.26% of the practice list.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the monitoring of patients with hypertension (high blood pressure) and reviewing patients with mental health conditions.

Effective staffing

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

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

proactive in providing training and funding for relevant courses, for example safeguarding, contraceptive implants and diabetes. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to two GP trainers or a senior GP throughout the day for support.

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

A Practice Nurse and two GPs were undertaking a university accredited certificate in diabetes care. As part of the learning the GP had undertaken an audit on impaired glucose intolerance which resulted in improved access to follow up appointments for patients diagnosed with diabetes and the setting up of a register and clinic for patients with impaired glucose intolerance which provided advice and support in reducing the risk of diabetes developing further complications.

Staff undertook annual updates training for a range of skills including resuscitation and emergency first aid. Training courses undertaken and planned were recorded on a database managed by the practice manager. However the practice did not routinely keep copies of all the training certificates from the training staff completed.

Working with colleagues and other services

We spoke with community nurses working with the practice, they told us about collaborative working and excellent working relationships with the practice. The manager of a nursing unit supported by the practice made similar positive comments about their working relationships and about the 'ward rounds' the doctor or nurse provided.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances recorded of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service, extended hours, and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings every two months to discuss the needs of complex patients. For example, those with end of life care needs or children on the at risk register. These meetings were attended by health visitors, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information. We saw procedures were in place to inform external organisations about any patients on a palliative care pathway. This included identifying such patients to the local out-of-hours provider.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use. The practice also used other forms of communication for services based in the practice. For example, they used a communications book for the district nurses team based in the practice to highlight important information about vulnerable patients.

Good

Are services effective?

(for example, treatment is effective)

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency (A&E). One GP showed told us about how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice employed a care coordinator to produce care plans. These were created in conjunction with patients when they visited the practice or by telephone. The patient signed and kept a copy of their care plan with the practice retaining a copy which was shared with other services such as the Out of Hour's service. The patient was also given a Gloucester Clinical Commissioning Group (CCG) 'Online Care Plan' card which they could share with services such as A&E to enable them to access their care plan. The Care coordinator followed up any referrals for care plans within 4-6 weeks and all patients discharged from hospital were followed up within two weeks.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (Vision) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

The manager of a nursing unit supported by the practice spoke about appropriate and relevant information sharing between the practice and themselves in support of their residents.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with had a basic understanding of the key parts of the legislation and were able to describe how they implemented it in their practice. However the practice nurse with responsibility for nursing home patients had not received formal training in the Mental Capacity Act 2005. Conversely they had undertaken specific safeguarding training with the Local Authority because of safeguarding concerns in care homes.

For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. The GPs we spoke with were able to show us patient records of where they had sought consent from patients for example, if minor surgery or an intimate examination was required. The patients consent had been recorded.

GPs we spoke with demonstrated an understanding of Gillick competencies. (These help clinicians to identify children under 16 years who have the legal capacity to consent to medical examination and treatment).

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans, in which they had been involved in developing, and had agreed to the content. These care plans were to be reviewed annually or more frequently if changes in their diagnosis were identified. A section stated the patient's preferences for treatment and decisions. The practice had signed up to local Directed Enhanced Services (DES) for patients with dementia. This initiative had been designed to reward GP practices who undertook a proactive approach to the timely assessment and support of patients known to be at risk of dementia.

Health promotion and prevention

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

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GPs were informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their

Good

Are services effective?

(for example, treatment is effective)

contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 91.2% of patients in this age group were offered a health check and currently 44.8% had taken up the offer. A GP showed us how patients were followed up within immediately if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed the majority of these patients had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 79%, which was in line with the average across the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named staff member responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was equal to or above average for the CCG. For example, immunisations for the DTaP/IPV/Hib vaccine (which protects children against diphtheria, tetanus, pertussis (whooping cough), and polio and Haemophilus influenza type b) had been achieved for 99.1% of young children and 98% had received their booster at two years of age. There was a clear policy for following up non-attenders by the named practice nurse.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital, who were taking multiple medicines or who were nearing the end of their life. An up to date care plan was in place for these patients and the information was shared with other providers such as the out of hour's service. All vulnerable older patients discharged from hospital had a follow-up consultation where it was required. Follow-up consultations were also made during routine appointments.

The practice employed a practice nurse with a responsibility for three care/nursing homes which cared for older patients who were registered at the practice. Each of the three care homes are allocated to a named GP. The practice nurse provides an annual health review of all residents registered with the practice in addition to reviews individual residents may require for long term condition management. The Practice Nurse also visits housebound patients annually to administer flu vaccinations. This service had been running for one year to offer care to meet the needs of the older patients in its population.

The majority of older patients had been offered cognition testing where it was felt appropriate. Most patients with a new diagnosis of dementia, had undergone relevant blood testing to check for other conditions. We saw evidence through meeting minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients in this age range. Each patient over 75 years was provided with a named accountable GP.

Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly GP and nurse led clinics were available to patients diagnosed with diabetes, Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers. These patients also had access to prompt appointments to ensure their needs were met.

Mother, babies, children and young people were supported by a range of relevant services and skilled and knowledgeable staff. A Safeguarding policy was in place and multidisciplinary meetings with both district nurse for adults and the health visitor for children under school age were provided. Where concerns were highlighted patients were placed on either the child protection register or the child in need register. Parent and child records were linked

Good

Are services effective?

(for example, treatment is effective)

to highlight concerns in families. Baby and pre-school clinics were held each Wednesday between 2 pm and 4.30 pm by appointment only. This clinic was for immunisations, medicals and developmental assessments, and was run by the health visitors and a doctor. We saw the practice nurses also used this clinic to carry out immunisations.

Child immunisations were checked regularly by the nursing team. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments. We saw routine audits were carried out by the practice to highlight non-attenders for immunisations and other appointments.

Working age patients were usually provided with their choice of appointment time, with routine practice appointments available from 8:30 am until 6:30 pm. Surgeries were also provided over lunchtimes and a phlebotomist was available every day of the week to cover lunch periods for patients to attend for blood tests. Both "book on the day" emergency and pre-bookable phone calls were also available throughout the day; the practice aimed to schedule these at mutually convenient times. The practice also offered extended hours on Tuesday and Friday mornings with appointments available from 7:00 am until 8:30 am and up until 7:00 pm on one day each week. The Choose and Book system was used to offer a choice for patient hospital referrals. A nurse led hormone replacement (HRT) clinics was held on Tuesday, Thursday and Friday afternoons. Flu vaccination clinics were provided on two Saturdays in October to increase availability to patients who worked.

Patients in vulnerable circumstances had access to a range of clinics and appointments. Health promotions such as breast screening, cytology and smoking cessation clinics, minor surgery was also routinely provided on Friday mornings.

The practice held a register of patients with a learning disability. Patients were invited to the practice for annual health checks through a standard letter offering a thirty minute appointment with a practice nurse followed up with a consultation with a GP. (It offered longer appointments for patients with a learning disability which incorporated annual health checks for other conditions such as heart disease).

Patients with a learning disability in residential care or supported living settings had appointments arranged through a telephone call to their home. The practice also phoned the home the day before the appointment as a reminder service. Patients who did not attend were followed up and if necessary this was done through their appointed support worker. Patients with difficulty attending the surgery were provided with a home visit.

Patients experiencing poor mental health who were on the practices mental health, learning disabilities, or dementia register were offered annual health checks; over half had taken up this offer. A Mental Health triage worker held weekly clinics at the practice for those patients who may benefit from more specialist care.

The practice had a dedicated carers noticeboard which supported carers from all population groups. Information was available about support groups, holidays and national carers organisations, other information was available in the practices patient handbook. Carers were offered annual health checks.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14 and a survey of patients undertaken by the practice's patient participation group (PPG). We also looked at comment cards completed by 28 patients during or before our inspection. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 94% of practice respondents saying the GP was good at listening to them and 88% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 28 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a wall and blind which helped keep patient information private. In response to patient and staff suggestions.

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

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 89% felt the GP was good at explaining treatment and results. Both these results were in line with other practices in the locality. The results from the practice's 2013 PPG report showed that 85% of patients said they were sufficiently involved in making decisions about their care. Comments and rating about nurses in the practice were similar to the GPs.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available. Other notices were available to help identify which language a patient spoke to enable the correct translation to be requested.

For older patients we saw evidence of care plans and patient involvement in agreeing these, each care plan was signed by the patient. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions. Children and young

Good

Are services caring?

people attending appointments told us they were treated in an age-appropriate way, and how GPs and nurses involved them in the consultation and acted on their preferences.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 92% said the last nurse they saw or spoke with was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this patient information. For example, these highlighted that staff responded compassionately towards carers and family members when they needed help and provided support when required.

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

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

GPs in the practice recognised isolation in older patients as a risk factor to their wellbeing and provided support through social prescribing to address this. For example, by supporting an older patient to access swimming sessions.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Gloucestershire Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. These included, more proactive and planned support to Care Homes, a wider range of care for patients with diabetes, following a comprehensive GP education programme, care for patients with suspected deep vein thrombosis (DVT) at their local GP practice, avoiding travel to hospital, early cancer diagnosis and GPs working with other health and social care professionals to support patients who are reaching the end of their lives, understanding their needs and developing their care plans.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included, the on-going promotion of the practices delivery of service message, closer monitoring of the health centres car park as people using the town centre were misusing the parking, enhancing patient privacy within the practice and ensuring appointments were available promptly. The members of the patient participation group we spoke with told us the practice responded well to these issues and recognised the car park issue affected all five practices in the health centre.

The practice had identified where they could support patients by reducing the need to attend hospital for minor operations. A GP with special interests provided minor operations in the practice weekly and two GPs carried out steroid injections as required.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients with a learning disability in a residential care or supported living setting had appointments arranged through a telephone call to their home. The practice also phoned the home the day before the appointment to offer a reminder service. Patients who did not attend were followed up and if necessary this was done through their appointed support worker. Patients with difficulty attending the surgery were provided with a home visit. The practice also provided home visits to older patients who were unable to attend the practice and to those living in residential or nursing home.

The practice had access to online and telephone translation services, notices were available to help staff identify which language a patient spoke to enable the correct translation to be requested. There were GPs and nurses who spoke six languages including Spanish, Polish, Urdu and Welsh The practices website could also be translated into a range of other languages.

The premises and services had been adapted to meet the needs of patient with disabilities. There were parking spaces for patients with disabilities and level access into the practice. Automatic opening doors into the main building assisted access into the waiting area and there was sufficient space for wheelchair users and parents with pushchairs to manoeuvre safely. There were accessible toilets and baby changing facilities. All consulting and treatment rooms were on the ground floor and only a short distance from the waiting area.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

Appointments were available from 8:30 am until 6:30 pm. Surgeries were also provided over lunchtimes and a phlebotomist was available every day of the week to cover lunch periods for patients to attend for blood tests. Both "book on the day" emergency and pre-bookable phone calls were also available throughout the day; the practice aimed to schedule these at mutually convenient times. The practice also offered extended hours on Tuesday and Friday mornings with appointments available from 6:45 am until 8:30 am and up until 7:00 pm on two days a week.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local care homes on a specific day each week, by a named GP and to those patients who needed one. Text message appointment reminders could be provided to patients who provided the practice with their mobile telephone number.

Patients were generally satisfied with the appointments system with 88% of patients who completed the GP national survey saying it easy to get through to this practice by phone. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how their child had become unwell before school and they were seen by a GP within two hours.

Appointments available outside of school hours for children and young people. Extended opening hours provided access to appointments for patients of working age and an online booking system was available.

Patients whose circumstances may make them vulnerable were provided with appointments at less busy times where it was identified that they may find this less stressful. Longer appointments were available for those that needed them.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England but had not been updated for some time. 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 in the patient information file and on the practices website. However the information was not easy to locate. None of the patients we spoke with had ever needed to make a complaint about the practice but told us they felt the practice would listen and respond to their concerns.

We looked at eight complaints received in the last 12 months and found information indicating these were satisfactorily handled. However the complaints log was out of sequence and lacked a chronology which showed the timeliness of the practices response or when actions were achieved. We saw evidence of action taken as a result for example, changing the way repeat prescriptions were managed. We saw from individual records that where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed by letter of the actions taken.

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

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly displayed in the waiting areas. The practice vision and values included, providing the highest quality care which meets the identified needs of patients; treating patients with courtesy, dignity and respect at all times; supporting patients to make decisions to improve and maintain their health; promoting best practice; putting patients at the centre of everything the practice does; and nurturing a practice culture which is innovative, forward looking and adaptable.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. We looked at minutes of the practice target days held over the last year and saw that staff had discussed the vision and values. The patients we spoke with about the practices values told us they felt these were being achieved.

Governance arrangements

The practice had a number of measures in place as part of its governance arrangements for example, audits, procedures, reviews, monitoring mechanisms, questionnaires and meetings. These individual aspects of governance provided evidence of how the practice functioned and the level of service quality delivered to patients.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at six of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. The majority of the policies and procedures we looked at had been reviewed annually and were up to date. However two policies we looked at were generic in their intent and did not fully reflect the practices approach. For example, the complaints procedure did not stipulate the need for a chronology of responses and the clinical governance policy lacked details about how the quality of patient care would be monitored and information shared with all staff groups.

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

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

The practice had an on=going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, reviewing their prescribing. However some audits were not repeated and so longer term benefits for patients could not be identified. Additionally a central log was not maintained of audits completed so that GPs and nurses could be made aware of the audits completed by individual clinicians.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. For example, ensuring appropriate recruitment took place and that premises maintenance was managed appropriately. We saw that the risk log was discussed at relevant staff and health centre meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a 'Medicines Optimisation Pharmacist' employed by the clinical commissioning group had been commissioned to work with the practice to review prescribing so that medicines were prescribed therapeutically and risk to patients was minimised.

Leadership, openness and transparency

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

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

The practice was proactive in planning for future needs; they told us they had commenced planning for the retirement of one GP. GPs and nurses were being provided the opportunities and access to additional training to cover some of the roles of the retiring GP, for example, diabetes and asthma. Recruitment processes had commenced for the replacement of the GP to ensure the practice could continue to deliver continuity of patient care.

The deputy practice manager held lead responsibility within the practice as the Caldicott Guardian and was clear about her role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place. The deputy practice manager was booked to attend a two day training course on the role in the near future.

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

The practice had gathered feedback from patients through patient surveys, complaints received and the recently implemented friends and family questionnaire. 226 patients responded to the 2014 patient survey, results were being collated by the practice at the time of our inspection. We looked at the results of the annual patient survey available on the practices website and 42% of patients agreed online appointment booking would be preferred; currently only 5% of respondents said they booked appointments in this way. We saw as a result of this the practice had promoted the use of online appointments. We reviewed a report on comments from patients made in 2013, which had a common theme of not liking the 0844 telephone number of the practice. We saw the practice had reverted back to using a 01242 number at their earliest opportunity after the feedback.

The practice had a small virtual patient participation group (PPG) which has struggled to increase in size. The PPG included representatives from various population groups; the working and recently retired and older patients groups. The PPG had carried out annual surveys and met two or three times a year. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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

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

Management lead through learning and improvement

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

The practice was a GP training practice with one female registrar GP placed in the practice. They were supported by two GP trainers in the practice as well as by the other partners each day.

The practice had completed reviews of significant events, complaints and other incidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice meeting agenda and were usually attended by the GPs, the practice manager and a practice nurse. Recent significant events were discussed and we were told by GPs they also reviewed actions from past significant events and complaints. There was evidence the practice had learned from these events and that the findings were shared. For example, taking

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better care when adding repeat prescriptions to the prescribing system. However, it was not always evident about how learning was shared across the whole staff group to improve services for patients.