

# The White House Surgery

## Quality Report

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

## Ratings

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

# Summary of findings

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## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The White House Surgery on 10 October 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- GPs at the practice supported the community hospital located on the same site and undertook regular ward rounds, two to three times a week on a rotational basis.
  - GPs who were skilled in specialist areas such as geriatric medicines and allergies, used their expertise to offer additional services to patients.

- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and 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.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The areas where the provider should make improvement are:

# Summary of findings

- Improve the recording of information such as minutes of meetings to ensure these are clear about the information discussed
- Review and improve systems and processes in relation to medicines management, staff training and appraisal.
- Implement the identified actions to improve the number of patients identified as carers.

**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?

The practice is rated as good for providing safe services.

Good



- From the sample of documented examples we reviewed, we found there was a system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- Although significant events were discussed and learning shared at weekly meetings, minutes of meetings were not always clear about the information discussed.
- There were arrangements for the safe management of medicines; however, there was a lack of records to demonstrate oversight of these arrangements. For example, the dispensary did not have a process to record near-miss errors and there was not always a record to describe what action had been taken when the fridge temperatures was outside of the normal range.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role.
- The practice had adequate arrangements to respond to emergencies and major incidents.

### Are services effective?

The practice is rated as good for providing effective services.

Good



- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- The practice had a programme of appraisals for staff. However, non-clinical staff had not received one in the last year. The practice told us that this was due to difficulties experienced by the practice in the last 12 months. There was a plan for those staff to receive an appraisal in the next few months.
- Staff had received training appropriate to their role.

# Summary of findings

- The practice supported patients to live healthy lives and had achieved a 100% quit rate for smoking cessation in 2016.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

## Are services caring?

The practice is rated as good for providing caring services.

Good



- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified 39 patients as carers (approximately 0.86% of the practice's patient list) and had identified ways to improve and increase the number of patients registered as carers. This included ensuring information was visible in the waiting area and a dedicated member of staff accurately recording patients who were identified as carers.

## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

Good



- The practice understood its population profile and had used this understanding to meet the needs of its population. The practice had identified that some patients could be isolated and therefore had raised the awareness of the social prescriber in the area should patients choose to use the services available to them.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia. The practice was able to admit patients to the local community hospital so that their health needs could be met more effectively in a short space of time by a range of health professionals and could be seen by one of the GPs at the practice more regularly.
- The practice hosted a range of services such as psychiatry, diabetes retinopathy screening, minor surgery, ultrasound and social prescribing so that these services were available locally for patients.

# Summary of findings

- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice provided 15 minutes routine appointments in the morning.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and evidence from three examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

## Are services well-led?

The practice is rated as good for being well-led.

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- Systems and processes had not ensured there was recorded information available to ensure governance oversight in relation to medicines management, staff training and appraisal. Minutes of meetings were not always clear about the information discussed.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities. There was a plan for non-clinical staff to receive an appraisal in the next few months as they had not received an appraisal in the last 12 months.
- The provider was aware of the requirements of the duty of candour. In five examples we reviewed we saw evidence the practice complied with these requirements.
- The partners encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.

Good



# Summary of findings

- GPs who were skilled in specialist areas such as geriatric medicines and allergies, used their expertise to offer additional services to patients.

# 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

The practice is rated as good for the care of older patients.

Good



- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services. For example, patients who were frail were discussed and treatment plans were amended as necessary with community staff and the out of hours service.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.

### People with long term conditions

The practice is rated as good for the care of patients with long-term conditions.

Good



- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients on the diabetes register with a record of a foot examination and risk classification was 99% compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- The percentage of patients with chronic obstructive pulmonary disorder (a chronic lung disease) who have had a review in the last 12 months (2015/16) was 91% compared to the CCG average of 93% and national average of 90%.



# Summary of findings

- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs. Those patients were also discussed at weekly clinical meetings.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

## Families, children and young people

The practice is rated as good for the care of families, children and young patients.

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.

Appointments were available outside of school hours and the premises were suitable for children and babies.

- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics. The practice hosted a weekly midwife clinic.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- One of the GPs could offer allergy testing and held a clinic for this for patients who suffered allergies.

Good



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

The practice is rated as good for the care of working age patients (including those recently retired and students).

Good



# Summary of findings

- The needs of these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, extended opening hours and telephone appointments.
- 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 supported a local training facility which had a number of students from the Middle East. One of the GPs could communicate with those patients in Arabic.

## People whose circumstances may make them vulnerable

The practice is rated as good for the care of patients whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice recognised that there was high number of patients who were travellers and had now settled in permanent accommodation locally. The practice discussed those patients beliefs and religions at weekly meetings to ensure staff understood this and supported patients appropriately.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable. The practice held Gold Standard Framework weekly meeting for patients on the palliative care register.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.

Good



# Summary of findings

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

Good



The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia).

- The practice carried out advance care planning for patients living with dementia.
- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the clinical commissioning group (CCG) of 86% and national average of 84%.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice worked closely with the Mental Health Community Team and could refer patients to the local crisis team and Gloucestershire counselling services. The practice had also identified private counsellors to whom, patients who were bereaved or required cognitive behavioural therapy could be referred.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- 79% of patients with severe mental health problems had a comprehensive care plan documented in their record in the last year (2015/16) which was below the CCG average of 93% and national average of 89%. Data from the practice for the year 2016/17, which was unverified, showed that this figure had improved. For example, 100% of patients had a care plan documented in their record.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published on 6 July 2017. The results showed the practice was performing in line with local and national averages. Two hundred and eighteen survey forms were distributed and 119 (55% completion rate) were returned. This represented approximately 3% of the practice's patient list.

- 86% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 89% and the national average of 85%.
- 77% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 73%.

- 83% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the CCG average of 83% and the national average of 77%.

As part of our inspection we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received 49 comment cards, of which, 48 were wholly positive about the standard of care received. Patients commented that the GPs and staff were polite and caring and that they received an excellent service from the practice. One comment card referred to a patient waiting a long time before they could see a female GP.

We spoke with three patients during the inspection. All those patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

# The White House 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 specialist adviser and two members of the CQC medicines team.

## Background to The White House Surgery

The White House Surgery (also known locally as Dr Morton & Partners) is based in Moreton-in-Marsh, a town and civil parish of Gloucestershire. In 2014, the practice moved from the high street in Moreton-in-Marsh to its current premises, The Four Shires Medical Centre. The Four Shires Medical Centre is a health care campus with a local community hospital, and is so named because the Four Shire stone marked the boundary of the historic counties of Gloucestershire, Warwickshire, Worcestershire and Oxfordshire. The White House Surgery shares a large, purpose built building with another GP practice, and its patients are drawn from the four counties.

The practice provides its services to approximately 4,500 patients under a General Medical Services (GMS) contract. (A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract). The practice also has a branch surgery and approximately 800 of registered patients use the branch. Both the practice's main site and branch surgery had a dispensary on site. The practice delivers its services from the following addresses:

The White House Surgery,  
Stow Road,

Moreton in Marsh,  
Gloucestershire,  
GL56 0DS.

And,  
The Surgery,  
Greenway Road,  
Blockley,  
Gloucestershire,  
GL56 9BJ.

There are four consulting rooms and three treatment rooms located on the ground floor, along with rooms for phlebotomy, psychiatry services, dispensing, midwifery and a baby clinic. The reception room is also situated on the ground floor. There is a patient lift and the building is suitable for disabled access. A large waiting room contains a plasma screen that relays NHS health information. The premises recently experienced a flood from a burst pipe and at the time of our inspection, the practice was undergoing remedial work. There were no disruptions to the services available to patients.

The practice partnership includes two male GPs. They also employ a salaried female GP. The nursing team includes an advanced nurse practitioner (who is also a non-medical prescriber), a practice nurse and a health care assistant. The dispensary team includes a dispensary manager and four dispensers. The practice management and administration team includes a practice manager, a systems manager, two medical secretaries, a lead receptionist and three receptionists (one of whom also provides phlebotomy services).

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice, shows the

# Detailed findings

practice is in the second least deprivation decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. Not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas). The practice has a higher than average patient population aged 50 and above. Average male and female life expectancy for the practice is 82 and 87 years respectively, which is above the national average of 79 and 83 years.

The practice is open from 8am to 6.30pm Monday to Friday. Appointments with a GP are from 8.30am to 5.30pm. Appointments in the morning were routinely 15 minutes long and 10 minutes in the afternoon. Extended hours are available from 6.30pm to 7.30pm on Monday evenings. The branch surgery is open from 8.30am and 12.30pm from Monday to Thursday.

The practice has opted out of providing out of hours services to its patients. Patients can access the out of hours services provided by CareUK via the NHS 111 service.

This inspection is part of the CQC comprehensive inspection programme and is the first inspection of The White House Surgery.

## 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. The 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.

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations for example, the clinical commissioning group to share what they knew. We carried out an announced visit on 10 October 2017. During our visit we:

- Spoke with a range of staff including three GPs, a receptionist, the health care assistant, the advanced nurse practitioner, the dispensary manager, the systems manager and the practice manager.
- We also spoke with a member of the nursing team from the community hospital and spoke with three patients who used the service.
- Observed how patients were being cared for in the reception area.
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations.
- Looked at information the practice used to deliver care and treatment plans.

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 were provided for specific groups of people and what good care looked 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 living with dementia).

## Detailed findings

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.

# Are services safe?

## Our findings

### Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From the sample of five documented examples we reviewed we found that when things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- Although significant events were discussed and learning shared at weekly meetings, minutes of meetings were not always clear about the information discussed. Following the inspection, the practice told us they had arranged for a member of the administration team to attend meetings where they would be designated to take minutes of meetings.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient had their blood tested and was given a prescription for a blood thinning medicine in case they required the medicine based on the result of the blood test. The patient was told that the out of hours service would contact them with the result and would advise them whether or not the medicine should be taken. When the practice contacted the patient later that afternoon to check if they had started the medicine as the result had been received, the patient confirmed that they had not started the medicine and neither had they been contacted by the out of hours service. The practice

investigated the records and found that although the out of hours service had noted the results, they did not contact the patient as the notes also said a prescription had been given to the patient. The practice identified that the system could be improved so that the information could not be misinterpreted. They therefore contacted the relevant people to amend the system to prevent the same thing happening again.

- The practice also monitored trends in significant events and evaluated any action taken.

### Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place.
- The advanced nurse practitioner was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and



## Are services safe?

staff had received up to date training. Annual IPC audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.

The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy.

The practice had signed up to the dispensary service quality scheme which rewards practices for providing high quality care to their dispensing patients. Dispensary staff completed medicine use reviews with patients. An example was given where changes had been made to the dispensing practice following patient concerns.

The practice had responded to concerns identified during the inspection to improve the safety and security of the management of medicines. (including obtaining, prescribing, recording, handling, storing, security and disposal).

Medicines were stored securely with access restricted to authorised individuals. Some medicines were stored in a treatment room where the air temperature was not monitored. Following the inspection, the practice purchased a thermometer to monitor the minimum and maximum temperature of this room. Fridge temperatures were recorded daily. However, when the fridge temperature was outside the recommended limits there was not always a record of the action taken. The practice investigated why the fridge temperature was outside the recommended range and found that this was due to drying and heating equipment being operated in the practice following the recent flood damage. They had also contacted the fridge manufacturers who provided assurance that should there have been a fault with the fridge, an alarm would have sounded.

All medicines we checked were within expiry dates. Staff explained that these checks took place. However, this process was not formal and no records were kept to demonstrate that the checks had been performed. Following the inspection, the practice sent us information to demonstrate how they had formalised this process as well as ensuring that checks were recorded.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements

because of their potential for misuse). They were stored securely and access was restricted to appropriate individuals. Suitable arrangements were in place for the destruction of controlled drugs.

Repeat prescriptions could be ordered by patients online, by telephone, and in person. The dispensary also managed a repeat prescription service for dispensing patients. Requests for high-risk medicines were checked to ensure that the necessary monitoring was in place before being issued and a process was in place to manage requests for medicines which needed to be reviewed by a GP. Repeat prescriptions were signed by a doctor before they were given out to patients.

There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. The standard operating procedures (written instructions about how to safely dispense medicines) had been signed by dispensary staff and were reviewed annually. A bar code scanner was used to check the dispensing process in addition to a second check by another staff member. The dispensary also offered patients weekly blister packs to support them to take their medicines.

The dispensary carried out regular medicines audits including looking at patients on high-risk medicines to ensure they had received the appropriate blood tests. Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken. However, there was no evidence that all staff members had been informed. Dispensing errors that reached patients were recorded and investigated but the dispensary did not have a process to record near-miss errors.

Emergency medicines were easily accessible to staff and were checked regularly to make sure they were in date and safe to use. They were held in a secure area and in a combination lock storage but were not tamper evident. The practice told us during the inspection that they would be purchasing tamper evident tags so that they were aware when emergency medicines had been accessed from the storage box.

Blank prescription pads and forms were stored securely and there was a system in place to monitor the distribution and use of printed prescriptions but not prescriptions that

## Are services safe?

could be handwritten. The practice sent us information following the inspection to demonstrate that a system had been introduced to monitor the use of handwritten prescription.

One of the nurses had recently qualified as an Independent prescriber and could prescribe medicines for clinical conditions within their expertise. Patient Group Directions (PGDs) were in place to allow nurses to administer medicines. (A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Authorised staff had been assessed as competent to use them and the directions were up to date so patients were treated safely. The health care assistant was trained to administer vaccines and medicines against a patient specific prescription or direction (PSDs) from a prescriber. (PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.)

We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS.

### Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- The practice had an up to date fire risk assessment and carried out fire drills in line with recommendations from a specialist contractor. Fire drill intervals were identified as required bi-annually, however the practice amended the frequency to annually so these took place more often. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.

- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients.

### Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 95%. The practice's exception rate overall was 11% which was in line the clinical commissioning group (CCG) of 12% and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/16 showed:

- The percentage of patients on the diabetes register with a record of a foot examination was 99% compared to the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- The percentage of patients with chronic obstructive pulmonary disorder (a chronic lung disease) who have had a review in the last 12 months was 91% compared to the CCG average of 93% and national average of 90%.

- 82% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the clinical commissioning group (CCG) of 86% and national average of 84%.

The practice used the QOF data to improve outcomes for patients and responded accordingly. For example, between 2015 and 2016 data showed that 79% of patients with severe mental health problems had a comprehensive care plan documented in their record last year which was below the CCG average of 93% and national average of 89%. However, more recent unverified data provided by the practice for the year 2016/17 showed that this figure had increased to 100% of patients.

Patients who required additional medical intervention for a short space of time could be admitted to the community hospital located on the same site where patients could be seen by healthcare professionals and their own GP more effectively. GPs undertook ward rounds twice daily, two to three times a week on a rotational basis which provided continuity of care to those patients.

The practice worked closely with the Mental Health Community Team and could refer patients to the local crisis team and Gloucestershire counselling services. The practice had also identified private counsellors to whom, patients who were bereaved or may benefit from cognitive behavioural therapy could be signposted.

There was evidence of quality improvement including clinical audit:

- There had been three clinical audits commenced in the last two years, one of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action included adding reminders to locum packs and on the prescribing screen on the practice's computer screen to ensure that antibiotic prescribing for children aged between one and 12 years was in line with current evidence based guidance. The actions implemented showed an improvement in prescribing with a locum GP undertaking the audit, reporting an improvement in their practice when compared to the first audit.

# Are services effective?

## (for example, treatment is effective)

Information about patients' outcomes was used to make improvements such as: for example, the practice recognised that allergies could affect children's performance in school and therefore offered allergy testing for those patients.

### Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, the advanced nurse practitioner who reviewed patients with long-term conditions had received updates in chronic obstructive pulmonary disease and diabetes.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. There was evidence to show that appraisals and personal development plans had been recorded for most staff. However, non-clinical staff were overdue an appraisal. We were told that this was due to difficulties such as recruitment and building damage experienced by the practice in the last 12 months. There was a plan in place for those staff to receive an appraisal by the end of 2017.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. Staff had received training appropriate to their role. However,

records for this training were not always recorded accurately to ensure there was oversight of staff training and to demonstrate that staff were up to date with training and education. The practice sent us information after the inspection to demonstrate that they were now implementing a matrix system which would give oversight of staff training.

### Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- From the sample of documented examples we reviewed we found that the practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The practice held Gold Standard Framework weekly meeting for patients on the palliative care register.

### Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

# Are services effective?

## (for example, treatment is effective)

- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

### Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation, bereavement and mental health.
- Smoking cessation advice was available from the health care assistant who had successfully supported 16 patients to stop smoking in 2016 which was a 100% quit rate.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the CCG average of 84% and the national average of 81%.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were above CCG and national averages. For example, rates for the vaccines given to under two year olds ranged from 91% to 100% ;five year olds ranged from 98% to 100% compared to the CCG average of 90% to 95% and national average of 88% and 94%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.



# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

Of the 49 patient Care Quality Commission comment cards we received, 48 were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. One comment card related to a patient waiting a long time before they could see a female GP.

We spoke with three patients. They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 90% of patients said the last GP they saw was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 92% of patients said the last GP they saw gave them enough time compared to the CCG average of 89% and the national average of 86%.

- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 98% and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 90% and the national average of 86%.
- 95% of patients said the nurse was good at listening to them compared with the CCG average of 93% and the national average of 91%.
- 99% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 93% and the national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, we spoke with a member of the nursing team from the community hospital, who told us that the GPs at the practice were approachable, caring and treated patients with dignity and respect. They were satisfied with the care and support from the GPs at the practice.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

## Are services caring?

Results from the national GP patient survey (2017) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 94% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 85% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 86% and the national average of 82%.
- 96% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that interpretation services were available for patients who did not have English as a first language. Patients were also told about multi-lingual staff who might be able to support them, for example, one of the GPs could also communicate in Arabic.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (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.

### **Patient and carer support to cope emotionally with care and treatment**

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 39 patients as carers (approximately 0.86% of the practice's patient list). The practice told us the reason for the low number of identified carers was because they had recently updated their records due to external organisations wrongly coding patients as carers on the computer system when this was not accurate. The practice told us of a number of improvements which would enable them to appropriately identify patients who were also carers. For example, one of the receptionists would be undertaking the role of summariser which would also include ensuring that patients were appropriately coded. The practice also used opportunities such as flu clinics to encourage patients to register as carers where appropriate. The practice also told us that they would install a dedicated carers board in the waiting area once the building work currently taking place has been completed. We saw there was a carer's information folder available in the waiting area with the various options of support available to them. The practice had also held a carer's afternoon in June 2017 at the practice and this was attended by various local voluntary organisations.

Staff told us that if families had experienced 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.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Monday evenings until 7.30pm for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- The practice recognised that there were high number of patients who were travellers and had now settled in permanent accommodation locally. The practice discussed these patients' beliefs and religions at weekly meetings to ensure staff understood this and supported patients appropriately.
- The practice had identified that some patients could be isolated and therefore raised the awareness of the social prescriber in the area should patients choose to use the services available to them.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice. The practice was able admit patients to the local community hospital so that health needs can be met more effectively in a short space of time by a range of health professionals and could be seen by one of the GPs at the practice more regularly.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. The practice provided 15 minute routine appointments in the morning to better meet patient's needs.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities, which included a hearing loop, and interpretation services available.

- The practice hosted a range of services such as psychiatry, diabetes retinopathy screening, minor surgery, ultrasound and social prescribing so that these services were available locally for patients.
- One of the GPs could offer allergy testing and held a clinic for this for patients who suffered allergies.
- The practice supported a local fire training facility which had a number of students from the Middle East. One of the GPs could communicate with those patients in Arabic.

### Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. Appointments with a GP were available from 8.30am to 5.30pm. Extended hours appointments were available from 6.30pm to 7.30pm on Monday evenings. The branch surgery was open from 8.30am and 12.30pm from Monday to Thursday. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey (2017) showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 71% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 91% of patients said they could get through easily to the practice by phone compared with the CCG average of 81% and the national average of 71%.
- 90% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 89% and the national average of 84%.
- 81% of patients said their last appointment was convenient compared with the CCG average of 87% and the national average of 81%.
- 77% of patients described their experience of making an appointment as good compared with the CCG average of 80% and the national average of 73%.



# Are services responsive to people's needs?

## (for example, to feedback?)

- 57% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The duty GP telephoned the patient or carer in advance to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

### **Listening and learning from concerns and complaints**

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.

We looked at three complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way. We saw there was openness and transparency with patients when dealing with complaints. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken as a result to improve the quality of care. For example, a patient complained about the way they were spoken to by one of the dispensing staff and added that they did not feel that they had been listened to. The patient suggested that if the phone call was recorded, the call could be listened to and if calls were not recorded, perhaps this could be arranged in future. When the practice investigated this complaint, they found that the facts could not be established to the conversation taking place over the phone. They therefore, made arrangements for phone calls to be recorded and for staff to receive training on customer care.

# 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.

- The practice had a mission statement which was displayed in the administration office and staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored.

### Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, there was a lead GP for safeguarding and GPs and the advance nurse practitioner had lead roles in the management of long-term conditions.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, however systems and processes had not ensured that the actions taken to minimise risk were recorded. For example, in relation to medicines management, staff training and appraisal. Minutes of meetings were not always clear about the information discussed.
- Meetings structure allowed for lessons to be learned and shared following significant events and complaints.

However, the minutes from these meetings were not always clear about the information discussed. Following the inspection, the practice told us they had arranged for a member of the administration team to attend meetings where they would be designated to take minutes of meetings.

### Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. From the sample of five documented examples we reviewed we found that the practice had systems to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by management.

- The practice held a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were

# Are services well-led?

Good 

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

involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

## **Seeking and acting on feedback from patients, the public and staff**

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- Patients through surveys and complaints received. The patient participation group met regularly carried out patient surveys and submitted proposals for improvements to the practice management team. The practice told us that the number of patients in the group had reduced due to poor health. The practice was looking at creating a virtual patient participation group to engage more patients in the running of the practice.
- Complaints and compliments received.
- Staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## **Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

Patients who required additional medical intervention for a short space of time could be admitted to the community hospital where they could be seen by healthcare professionals and their GP more effectively. GPs undertook ward rounds twice daily, two to three times a week on a rotational basis which provided continuity of care to those patients.

The practice offered their facilities to be used by other services so that services were available more locally to patients. This included services such as psychiatry, diabetes retinopathy screening, minor surgery, ultrasound and social prescribing. There was a dedicated room with computers set up for community staff to use.