Locking Hill 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?	**Requires improvement**
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 Locking Hill Surgery on 14 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to require improvement for providing safe services. It was good for providing effective, caring, responsive and well-led services for older people, people with long term conditions, families children and young people, people of working age including those recently retired an students, people whose circumstances make them vulnerable and people with poor mental health including people with dementia.

Our key findings were as follows:

- Data showed patient outcomes were at or above the average for the locality.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had a clear vision and strategy and staff were clear about the vision and their responsibilities in relation to this.
- The practice proactively sought feedback from patients which it acted on.
- The practice engaged with an external consultant to review the appointments system and changed what they were doing. The day was divided into three shorter surgeries so that appointments were more likely to be on time and patients had access to appointments at lunchtime.
- A 'late start GP' often covered urgent morning visits rather than patients having to wait until lunchtime.

Summary of findings

- Triage nurses who saw patients the same day for minor illness. As the practice offered same day access appointments any patient who felt they needed to be seen the same day could have an appointment.
- The practice had started a comprehensive audit on atrial fibrillation (irregular heart rhythm) and whilst this has not been completed had raised awareness in the practice of routine pulse checks in older patients and those with cardio-vascular risk factors.
- Same day appointments were available for patients with poor mental health.
- If patients with poor mental health did not attend for an annual review and were not seen opportunistically when their mental health could be reviewed a GP would arrange to visit them.

We saw an area of outstanding practice:

- GPs discussed with patients the options available to them for their health and wellbeing. This included options for prescriptions for counselling services , access to an exercise facility or self-help books and art therapy.

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

Importantly, the provider must:

- Ensure the practice has a health and safety policy, to include contingency planning in the event of an emergency . This must include assessment of risk to patients, staff and visitors to the practice and measures to minimise those risks.

In addition the provider should:

- Record as evidence, the induction and all training completed by staff.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Although the practice responded well following a flood in 2007 when there was only minimal disruption to services, there was no written contingency plan. The practice did not have a health and safety policy and there were no risk assessments. Blank prescription paper was left in unsecured rooms. In addition, there was no proof of identity in one of the staff records we looked at and only one written reference was obtained for some staff.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence 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 told us they had received training appropriate to their roles and any further training needs had been identified and appropriate training was planned to meet these needs. There was evidence of appraisals for all staff, although some staff told us their appraisal was overdue. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. National data showed that patients rated the practice higher than the England average 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

Summary of findings

appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints 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 patients, which it acted on. Staff had 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 patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, providing an enhanced service to care homes. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of patients 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 patients over the age of 75 years had a named GP and a structured annual review to check that their health and medication 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

Good

The practice is rated as good for the care of families, children and young patients. There were systems in place to identify and follow up children living in disadvantaged circumstances. Immunisation rates were relatively high for all standard childhood immunisations. . 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. At each surgery there were two allocated slots for patients to 'walk in' for contraceptive advice including those who were not registered with the practice.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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.

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable. The practice held a register of patients with learning disabilities. It had carried out annual health checks for people with a learning disability and it offered longer appointments for patients with a learning disability.

We were told the practice took a flexible approach with the requirements for identification when new patients registered as some patients may have no fixed abode or photographic identification. Same day appointments were available for those who may have more chaotic lifestyles.

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

People experiencing poor mental health (including people with dementia)

Good

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

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.

Same day appointments were available and annual reviews were offered to patients with poor mental health. If they did not attend they were sent up to three letters inviting them to make an appointment for a review.

Summary of findings

What people who use the service say

We looked at the patient survey results for 2013/14. They showed the percentage of patients who would recommend the practice was higher than the Clinical Commissioning Group average and the England average. Similarly there was a higher percent of patients who were satisfied with telephone access, practice opening hours and patients reporting a good overall experience.

We sent comments cards to the practice in advance of our inspection and 10 were completed. Patients told us about being treated with kindness, satisfaction with the service provided and quality of care. Staff were referred to as helpful, polite, caring and friendly. Patients also told us about the ease with which they were able to have an appointment and being seen by the right person on the same day.

We spoke with five patients on the day of our inspection. They told us they felt the practice was well led and they were involved in decisions about their care. Patients spoke about the cleanliness of the practice. They also told us how quickly they had been referred for secondary care when this was necessary. Patients also told us about the good communication they experienced with practice staff.

We received information from Healthwatch Gloucestershire dated 2013/14. Healthwatch held listening events in Stroud and Gloucester and patients from the practice gave feedback. Comments were mixed however most were positive. Some patients praised the practice for the empathetic GPs and the good service they received. Some patients told Healthwatch about the difficulty getting an appointment and accessibility for patients with physical disabilities.

Areas for improvement

Action the service MUST take to improve

- Ensure the practice has a health and safety policy, to include contingency planning in the event of an emergency . This must include assessment of risk to patients, staff and visitors to the practice and measures to minimise those risks.

Action the service SHOULD take to improve

- Record as evidence, the induction and all training completed by staff.

Outstanding practice

- GPs discussed with patients the options available to them for their health and wellbeing. This included options for prescriptions for counselling services , access to an exercise facility or self-help books and art therapy.

Locking Hill 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 advisor and a practice manager, specialist advisor.

Background to Locking Hill Surgery

The Locking Hill Surgery is a partnership of six GPs and there are two salaried GPs. They have appointed a practice manager to oversee the day to day management of the practice and employ a range of clinical and administrative staff. District nurses are based in the practice and community midwives hold clinics there.

The surgery was purpose built in the early 1980s and is set over two floors with all patient access areas on the first floor. It has a ramp and steps to the entrance of the building. There is a separate reception area with an automated arrival system and spacious waiting room. There are six consulting rooms and three treatment rooms.

The practice has in excess of 9,000 patients and is in the third least derived decile.

The practice contracts Out Of Hours services to the Gloucestershire Out Of Hours service provided at Stroud hospital.

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.

How we carried out this inspection

We carried out an announced visit to the practice on 14 January 2015 when we spoke with staff and patients and looked at records. In advance of the inspection we reviewed the information available to us about the practice and consulted with Gloucestershire Clinical Commissioning Group, NHS England local area team and Gloucestershire Healthwatch. We sent comments cards to the practice in advance of our visit for patients to complete.

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:

Detailed findings

- 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)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. If new guidelines were received, from organisations such as the National Institute for Health and Care Excellence (NICE), they were discussed at the clinical meetings. When patient safety alerts were received they were disseminated to the GPs and nurses by the practice manager.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We discussed significant events with GPs. One GP told us about a complaint which had been resolved satisfactorily with a patient. The GP said that they felt well supported within the practice during this process.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were discussed monthly. These included the death of any patient registered with the practice and the cause of death was coded for analysis. The practice considered some serious cardio vascular episodes as a significant event and also included patients with a diagnosis of diabetes who presented at the practice as being hypoglycaemic and any diabetic patients requiring hospital admission due to diabetic complications, as significant events.

We looked at records of significant events that showed a brief description of the event and key issues arising from analysis. Areas of concern were identified along with suggestions to prevent recurrence, actions to be taken and date for review. The significant event forms were completed in full and showed the learning from events.

The district nursing team told us how they were involved in meetings to discuss significant events. They told us any concerns they raised were followed up and appropriate referrals were made when clinically indicated.

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 on safeguarding. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The GP partner who was registered as manager of the practice with CQC was the 'lead' for child protection and safeguarding vulnerable adults. All of the GPs were trained to Level 3 in child protection and had competed safeguarding vulnerable adults training. Other staff had competed child protection training at levels 1 and 2. We saw evidence of this training on file.

The practice safeguarding lead attended three monthly county wide safeguarding meetings to keep up to date.

There were three monthly multi-agency meetings held in the practice to discuss patients on the practice safeguarding register.

The administrator told us about their involvement in the three monthly meetings held to discuss those on the practice register. They said they liaised with health visitors and school nurses and had once raised a concern that led to a child having a protection plan.

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. Staff told us they competed on-line training in child protection and safeguarding vulnerable adults. One of the nurses we spoke with told us where they could find relevant telephone numbers for reporting suspicions or allegations of abuse and could identify the practice lead person. They said the computer records system identified those patients who were on the practice register.

Staff we spoke with told us they would report colleagues, if they thought their behaviour was inappropriate. Several members of staff said they would address issues with the colleague in the first instance.

The chaperone policy was displayed in each of the consulting rooms and treatment 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. The practice policy described what constituted an intimate examination, identified who could

act as chaperone and outlined the procedure. It referred to maintaining confidentiality and assessment of capacity to consent to examination and the use of a chaperone. Two non clinical staff had trained to act as chaperone.

Medicines management

The practice liaised with the Gloucestershire Clinical Commissioning Group (CCG) pharmacy advisor and we were told the practice engaged with them in projects and suggested changes to prescribing regimes.

We were told the practice actively promoted repeat prescribing for patients who were prescribed multiple medicines. There were good links with the local pharmacies and medicines could be dispensed into monitored dosage packs and delivered to patients at their home. The practice lead for prescribing liaised with a pharmacy advisor and discussed changes at the clinical meetings. It was the practice aim to reduce waste, improve efficiency, prescribe safely and in a cost effective way.

The practice had systems in place with pharmacies nominated by patients. Prescriptions were sent to the pharmacy and this proved to be efficient for stable prescriptions but not suitable for patients who had frequents changes in medicines. The practice usually prescribed repeat medicines for 56 days at a time to reduce the burden on patients. There was a posting box in reception for repeat prescriptions.

If the practice had concerns relating to patients being non-compliant with taking their prescribed medicines the practice would telephone the patient and ask them to make an appointment to see their GP. Also, if patients were overdue health or medication reviews there was a recall system in place by adding reminders to prescriptions.

There was a controlled medicines policy. Some prescription medicines are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs. Stricter legal controls apply to controlled medicines to prevent them being misused, being obtained illegal and causing harm. The policy included a general statement and advised on the ordering, receiving, storage, access and record keeping in relation to controlled medicines. There was also guidance on removal and disposal of the medicines to show the practice intent to comply with legislation. Controlled medicines were kept in the practice appropriately. The controlled medicines register was held in one of the treatment rooms. Other medicines were also kept in treatment rooms. We looked at medicines held in the practice and saw arrangements had been made for their secure removal and disposal. Medicines were checked monthly to ensure they were in date and safe to use.

One of the nurses maintained a list of the medicines GPs carried with them when carrying out home visits. They told us they would advise the GP if medicines were near their use by date so they could obtain replacements.

We were told if there was a prescribing error it would be treated as a significant event and discussed at practice meetings.

We found blank prescription paper was kept in the computer printers. Consulting rooms were lockable internally but not from the outside. When we brought this to the attention of the provider as a security risk, they told us they would look for a solution.

One of the nurses confirmed there were patient group directions for the administration of vaccines. In the case of contraceptive implants the directions were related to individual patients (patient specific directions).

Cleanliness and infection control

We saw the infection control policy and protocols included general precautions and decontamination and disposal of materials including clinical waste. There was guidance for staff on the taking of blood samples, handling of specimens and biological substances. We also saw there was also information relating to the giving of vaccinations and disposal of sharp instruments.

There was hand washing guidance displayed in treatment rooms.

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.

We saw evidence of an infection control audit. It showed 100% compliance with hand hygiene requirements, spillage and contamination with blood/body fluids and the wearing of personal and protective clothing and equipment. The practice rated itself as 89 % compliant with

environmental requirements, 91% compliant with waste requirements, 94% compliant with specimen handling, 90% compliant with decontamination and 84% complaint with vaccine storage and handling.

Actions arising from the practice audit were concerned with staff training, updating policies and better information. There were also actions relating to the cleaning of blinds and replacement of a damaged couch.

We also did an infection prevention and control audit that considered hand hygiene, safe handling of sharp instruments, the environment, use of re-useable equipment, waste, immunisation of staff and safe handling of specimens.

The practice held a contract with an external cleaning company. Following an audit by the company there were new cleaning regimes put into place as the company felt the service was unsatisfactory. The practice manger confirmed arrangements were improved.

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.

We saw equipment was calibrated and in date showing it was safe for use. There were records of servicing to the boiler, fire alarm and intruder alarm systems. Portable electrical equipment had been tested annually.

Staffing and recruitment

We looked at the recruitment records for four staff. They showed staff applied for a position within the practice by submitting a curriculum vitae (CV) and were issued with a contract of employment. Efforts were made to obtain two references however in some cases the practice was only successful in obtaining one. We saw most staff had provided proof of identity and right to work however, in one of the records we looked at, this was missing. In the four records we looked at staff had criminal records checks through the Disclosure and Barring Service. GPs and nurses were checked at enhanced level. We saw all GPs and nurses had immunisation against the Hepatitis B virus.

The registered manager told us the workload of the practice manager was being reviewed as there was a feeling they were over stretched. They had given the practice manager more autonomy during the past year to enable them to be autonomous.

We were told that the practice rarely used locum GPs but if necessary had a small number that they would use.

At the time of our visit there were two staff vacancies. One of these was for a full time healthcare assistant and the other for a receptionist/administrator.

Monitoring safety and responding to risk

The practice could not show us a fire safety procedure or evidence fire drills were held. Shortly after our visit we were sent the practice fire safety policy and evidence a drill had been carried out.

Fire fighting appliances were tested annually by an external contractor to ensure they were working efficiently. We were told staff had received training in the use of fire fighting equipment but there was no evidence of this. The practice manager told us the fire officer had visited in the practice but there was no evidence of the visit available.

The practice did not have a health and safety policy and no evidence of risk assessment having been conducted. There was no evidence of an electrical installation test having been undertaken.

Arrangements to deal with emergencies and major incidents

Each year all of the staff attended training in cardio pulmonary resuscitation and basic life support. There was a dedicated trolley that held all of the equipment and medicines for use in an emergency. A nurse told us they checked the medicines each week and we saw records of these and the visual checks of equipment. We saw all of the medicines were in date and equipment was calibrated annually. The nurse told us of a cardiac arrest in the practice and how the patient had been resuscitated successfully and had survived.

The practice did not have an emergency contingency plan. However, when the practice was flooded in 2007 the staff worked together to ensure continuity of service. The flooding occurred on a Friday afternoon and staff worked together so that the practice could function on Monday morning. The practice staff worked together and held surgeries in GP practice in various parts of Stroud.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We were told the practice operated a 'usual GP' model where in order to maximise continuity of care the practice tried to arrange for patients to see the GP they were registered with. A 'buddy system' meant that the same GP covered when their 'buddy' GP was on leave. The registered manager told us they felt this was particularly beneficial for older patients with complex needs and people with long term conditions..

The GPs at Locking Hill Surgery had special interests in musculoskeletal and sports medicine, eyes, and ear, nose and throat (ENT) and cardio-vascular medicine. Three of the GPs provided full contraceptive services and endometrial biopsies were also offered. During an endometrial biopsy, a sample of the endometrium, the lining of tissue in the uterus, is taken to check for abnormalities.

There were two nurse prescribers within the nursing team who ran daily minor illness clinics. In addition there was a nurse who specialised in the assessment and treatment of patients with asthma or chronic obstructive pulmonary disease (COPD), a diabetes specialist nurse and a contraception specialist nurse.

Specialist clinics were held for patients with these conditions. In addition there were clinics for child health and immunisation, hypertension (high blood pressure) and minor surgery, such as the removal of warts.

The practice held an enhanced contract to prevent unplanned hospital admissions. All of the GPs were involved in care planning for patients who were 'at risk'.

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 audited its use of compression stockings in patients who had a deep vein thrombosis (DVT). It concluded the practice was not prescribing the wearing of compression stockings in line with guidance and should increase this when patients had a DVT. They planned to review the audit in 2016.

One of the nurses told us how they audited the management of diabetes in patients. If patients were found to have poor control they were monitored more closely. They told us that in 11 out of 14 patients diagnosed with diabetes there was improvement in their management of the condition.

We saw audits in respect of the monitoring of patients with coeliac disease which showed 10 of 35 patients had not had a blood test within the previous 12 months. Action taken by the practice was to write to those patients to inform them of the need to have the blood test.

There was also an audit of soft tissue steroid injections given to check the efficacy of the treatment. For each type of injection there were outcomes recorded. The audit showed where symptoms were reduced and further action taken where there was no improvement. Generally results were positive.

We also saw a audit of patients with gout which showed good results.

We spoke with the audit coordinator. They were responsible for maintaining Quality and Outcomes Framework (QOF) registers and for monitoring repeat prescribing. They told us they maintained an on-going dialogue with GPs and nursing staff to keep them up to date with achievements. They told us they had regular meetings with the GP lead for QOF to review progress. The QOF results for 2013/14 showed 94.7% achievement of QOF points with 100% attained in the management of asthma, atrial fibrillation,, chronic kidney disease and epilepsy. In addition the practice achieved 100% for the care of patients who suffered heart failure and osteoporosis. It scored 100% for palliative care and for meeting the needs of patients with learning disabilities.

The practice identified a GP partner for each of the Quality and Outcomes Framework (QOF) conditions. The QOF is a

contract that exists between GP practices and the NHS to provide services and is measured by monitoring patients with long term conditions. Each of the partner GPs has looked at ways of improving service for patients by focussing on a QOF condition.

For patients with learning disabilities there were annual checks conducted by the practice nurse. These included physical checks such as blood tests, blood pressure check and a check of body mass index (BMI). They also discussed lifestyle with the patient and checked immunisation status and whether they were up to date with cervical screening. They collated all of the information prior to the patient being seen by a GP.

The practice had a recall system for patients with long term conditions. The practice diary clearly identified when specific clinics were held so that patients with long term conditions could be booked in for the correct appointment. There was guidance for nursing staff for the tests required in respect of long term conditions.

Patients with chronic obstructive pulmonary disease could be referred to the community respiratory team for pulmonary rehabilitation if needed.

One of the GPs had a particular interest in the prevention of stroke in patients with atrial fibrillation. The practice was part of a pilot study for early detection atrial fibrillation was diagnosed an anti-coagulant (blood thinning) medicine was started which reduces the risk of having a stroke.

We spoke with an independent pharmacist who was auditing the practice to determine whether National Institute for Health and Care Excellence (NICE) guidance on the management of atrial fibrillation from June 2014 was being followed. They were working closely with the specialist GP and calling in patients for medical review and reviews of medication if necessary. Also at the end of the audit they would feedback recommendations to the practice. One of the nurses we spoke with told us they were aware of the audit and was expecting practice guidelines and training in relation to atrial fibrillation and stroke prevention.

One of the GPs was the clinical lead for the Gloucestershire Clinical Commissioning Group cardio vascular disease programme.

The practice used a QOF based template with added parameters that were not included in the QOF such as recording of urine test results. Patients who were newly diagnosed with diabetes were identified within the recording system so that when recalls for tests were needed, no one was missed.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. The registered manager told us how the practice had managed staffing issues and took employment advice when necessary.

The administrator/receptionist assisted the practice manager. They organised the running of the surgeries and maintained the office diary. They also arranged the rota to ensure the reception was covered at all times.

We spoke with staff who told us about the training available to them. One of the medical secretaries told us there was specific training when 'choose and book' was introduced and when the practice changed its IT system. Most of the administrative staff had completed customer service training. There was training planned for the day after our visit relating to electronic prescribing.

One of the nurses told us about the family planning training they attended every two years and how this helped to maintain continuing professional development requirements (CPD).

Another nurse told us they had a certificate in diabetes care and had on-going training in initiating diabetes controlling medicines including oral medicines for the condition. Every four to six months they attended a diabetes study day.

One of the GPs told us about their involvement with the Local Medical Committee (LMC) and how this helped with personal development and the development of the practice. They said the involvement with the LMC stimulated their interest in the psychology of management.

One of the salaried GPs told us about the protected learning time they had for Continuing Professional Development (CPD) and about the regular updates they attended in women's health and family planning.

We did not see evidence of staff induction or training in the staff files we looked at.

Staff told us about the weekly meetings some of which were of a clinical nature and an outside speaker was invited.

Good

Are services effective?

(for example, treatment is effective)

Staff told us they had annual appraisal and they felt able to contribute to the process. One of the nurses spoke positively about the process and highlighted how it had encouraged them to develop their skills. Some of the staff said their appraisal was overdue.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. The district nursing team were practice based which allowed for effective communication. We received feedback from the team. They told us they felt the practice provided safe effective care to its patients. They said they did joint visits to patients receiving palliative care and those with complex health needs. The district nurses referred to good communication between them and the practice staff who they described as friendly and caring.

We saw there was a 'palliative care register'. Patients nearing the end of life were identified within the patient records system so staff were aware of this. Any urgent requests for medicines or appointments were sent to the patient's 'usual GP'. As the district nurses were based in the practice there were opportunities for discussion about any concerns with a patient. If a patient nearing the end of life elects to have a 'do not attempt resuscitation' directive this is identified on the records system and made available to the Out Of Hours service. One of the GPs spoke about the good liaison with the local hospice and palliative care consultants.

The practice was signed up to provide an enhanced service to care homes and linked with 10 care homes in the area. Each of these services had a named GP to provide continuity of care.

A template was set up to record the healthcare needs of patients in the homes. Each patient had a six monthly medicines review and the GPs were involved in falls prevention, diabetes management and cancer care. In addition there was advanced care planning and in some cases 'do not attempt resuscitation' directives. We were told the involvement of a GP with each of the homes provided much more structured care and more involvement of patient's carers and families.

There were a team of three part time medical secretaries. One of them we spoke with told us how they liaised with each other to ensure work was passed on and that queries were resolved.

We spoke with a group of three administration staff together. They demonstrated how incoming documents were scanned the day they were received and passed to GPs through the practice electronic 'workflow' system. Any documents received from the Out Of Hours service were scanned the same day.

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.

The practice received information about patients who had attended the Accident and Emergency Department. The practice could refer patients to the local authority occupational therapy services if this would be useful.

Consent to care and treatment

One of the GPs told us how they encouraged decision making during consultations and used information leaflets to assist with this. They gave examples of how they had used arthritis research and contraceptive advice leaflets to help patients understanding so they were able to make a decision.

The consent policy offered a definition of consent. It also outlined the procedure to be followed when a patient lacked capacity and further guidance. The policy also referred to 'Gillick competence' and young people's ability to give consent if they demonstrated understanding of the treatment they were being offered.

We spoke with a nurse who provided family planning services. They told us they would take Gillick competence into account when prescribing contraception to patients under the age of 16. They said they would check the age of the patient's partner and discuss any patient under the age of 13 years with the practice safeguarding lead GP.

The nurse told us if they were prescribing to a patient with learning disabilities they would involve the patient's GP and next of kin to ensure the greatest level of consent.

There was information available for staff in relation to the Mental Capacity act 2005. It referred to the core principles of the Act, assessment of capacity and best interest decisions. There was guidance on recording assessments

and decision and reference to the involvement of Independent Mental Capacity Assessors (IMCA). The information included guidance of advance directives for end of life care.

Some of the GPs had completed on-line training in mental capacity, were aware of the steps to take to assess capacity and understood the role of IMCA.

We spoke with one of the nurses about mental capacity. They had not received any formal training but were aware that they should assume a patient had capacity to consent. They told us they would seek advice, if needed. One of the nurses told us about a patient who was unable to cooperate with spirometry, a test for lung function, due to their dementia. They liaised with one of the GPs regarding this.

We spoke with the GP with lead responsibility for mental health. They were aware of referral pathways for patients with poor mental health including access to psychology services and the recovery team for patients who were more unwell and had on-going problems.

Same day appointments were available and annual reviews were offered to patients with poor mental health. If they did not attend for a review they were sent up to three letters inviting them to make an appointment for a review. Most patients with poor mental health had care plans (75%) that included contact information of their carers or relatives.

The local mental health nurse held a weekly clinic in the practice.

One of the GPs told us if a patient presented with confusion or memory difficulties they would screen them for dementia carrying out the necessary tests. They told us they would discuss referral to secondary care for a consultant appointment as appropriate.

A GP told us they may use screening questionnaires with patients who presented with anxiety or depression. GPs discussed with patients about the options available to them for their health and wellbeing. This included options for prescriptions for counselling services , access to an exercise facility or self-help books and art therapy. GPs could liaise with the community psychiatric nurse if needed.

Health promotion and prevention

New patients were required to complete a new patient registration form and were invited to attend a screening appointment. The practice leaflet and website explained how it may take some time for medical records to be transferred and the appointment would give the opportunity to discuss any concerns. The appointment would also check immunisations were up to date and record regular medicines.

There were a range of information leaflets available for patients to take away with them. Some were related to health conditions such as stroke and diabetes and others related to self-help such as smoking cessation.

We were told the practice supported its patients to live healthier lives by referring patients to smoking cessation clinics, exercise on prescription and books on prescription. It also referred some patients for assistance with weight loss.

The nurse who provided family planning services said that if patients arrived for their appointment with a young friend they would take the opportunity to speak with their friends about sexually transmitted diseases and encourage them to take a home testing kit for Chlamydia.

The practice was signed up to provide an enhanced service for sexual health. At each surgery there were two allocated slots for patients to 'walk in' for contraceptive advice including those who were not registered with the practice. The practice leaflet contained useful information for patients who were trying for a baby including diet and lifestyle.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We saw the practice confidentiality statement displayed in the waiting area. Staff signed to indicate they agreed to maintain confidentiality and the policy outlined the responsibilities of staff.

The practice was gathering data including email addresses and mobile telephone numbers for patients so that patients could be sent email or text reminders when their appointments were imminent. One patient we spoke with thought this would be a good development.

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 93% of practice respondents said the GP involved them in care decisions and 96% felt the GP was good at explaining treatment and results. Both these results were above average for the Gloucestershire Clinical Commissioning Group area and the average for England.

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

Patient/carer support to cope emotionally with care and treatment

The practice had a carer's protocol that outlined how carer's would be identified through the new patient registration process and through self-referral so that their caring responsibilities could be taken into account during any consultation. There was information for carer's displayed including a list of useful websites. One of the nurses we spoke with told us how they offered influenza vaccination to carers and offered advice regarding support for carers.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GP partners recognised that the premises were too small and they had been unable to offer all of the services they would have preferred to. Plans were drawn up for a new facility and reached the final planning stages however the project fell through. The partners were actively looking for a suitable site.

Given that the practice was expected to move there had been little investment in the property however now that plans have fallen through we saw the practice had obtained quotes for general redecoration, improvement to clinical areas and upgrading toilets including the installation of a wheelchair accessible toilet.

Tackling inequity and promoting equality

One of the GPs told us about their concerns for a patient with learning disabilities who declined referral to secondary care treatment. They said they discussed the issue with the GP partners so they were aware of the situation and could make a decision about care based on the patient's best interests.

The practice used a special questionnaire to record the health and well-being of patients with learning disabilities. It recorded information relating to their physical and mental well-being in addition to listing information related to their specific learning disability.

We were told the practice took a flexible approach with the requirements for identification when new patients registered as some patients may have no fixed abode or photographic identification.

Same day appointments were available for those who may have more chaotic lifestyles.

If patients whose circumstances made them vulnerable arrived late for an appointment the receptionist would liaise with the GP in order to provide a flexible approach and maintain continuity

Patients with substance addictions were booked appointments to see their 'usual GP' for continuity. There were strict prescribing rules in relation to quantity of medicines and 'lost' prescriptions and patients could only obtain from a GP and not as a 'repeat'. The practice could refer to a national health and social care organisation that could support patients who abused alcohol and substances.

Access to the service

The registered manager told us how the practice had worked hard to improve patient access. They engaged with an external consultant to review the appointments system and changed what they were doing. The practice had a range of appointments from 7 am on two days each week and until 8 pm on two days. A 'late start GP' covered urgent morning visits rather than patients having to wait until lunchtime. The day was divided into three shorter surgeries so that appointments were more likely to be on time and patients had access to appointments at lunchtime.

There were two triage nurses who saw patients the same day for minor illness. A triage nurse told us there were not many patients who having been seen by in triage also needed to see a GP. As the practice offered same day access appointments any patient who felt they needed to be seen the same day could have an appointment. There were early morning, late evening and lunchtime appointments available.

There was a duty GP responsible for home visits that were arranged so they took place during the day. At each surgery there were two allocated slots for patients to 'walk in' for contraceptive advice.

We spoke with three administration staff in a group. They told us how they had four telephone lines to answer incoming calls and used a checklist for triaging requests for appointments or telephone consultation.

The practice contracted it's Out Of Hours services to the Gloucestershire Out of Hours service provided from Stroud hospital. At lunchtime when the practice was closed to telephone calls they were directed to the message link service for one hour and if necessary the practice could be contacted on a different, dedicated telephone number.

There was evidence that the practice took safety into account when organising consultation length and surgery times.

The patient leaflet explained that prescriptions would be ready for collection two working days after a request was made. Patients could request repeat prescriptions in writing, by fax or through the practice website.

Good

Are services responsive to people's needs?

(for example, to feedback?)

When patients had tests the practice contacted them to arrange a follow up appointment if the results were abnormal and further action needed to be taken.

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 and there is a designated responsible person who handles all complaints in the practice.

The complaints procedure was displayed in the waiting area and outlined in the practice leaflet. It said that the practice always tried to provide the best possible service but that there may be times when patients feel this has not happened.

It directed patients to contact the practice manager in writing or by telephone and informed how it would be acknowledged within two working days and a response received within 10 working days.

The procedure gave the telephone contact details for Gloucestershire Clinical Commissioning Group as patients had the right to contact them.

One of the patients we spoke with told us they knew how to make a complaint. Another patient said they had made a complaint and it was resolved to their satisfaction.

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 charter standards outlined how the team at Locking Hill were committed to providing patients with the highest standard of health care. It said the practice would aim to give patients the best advice and information to achieve and maintain better health and provide the best healthcare possible.

There was an ethos of team working in the practice. A member of staff described the practice manager as approachable and supportive. Other staff spoke about the good communication and support within the practice and how they felt staff genuinely cared about each other. All staff said Locking Hill Surgery was a nice place to work.

Governance arrangements

Practice policies and procedures to govern activity were contained in the surgery handbook and were available for staff on the practice computer system. We looked at a range of these and saw they related to clinical issues, patient alerts and safeguarding. In addition the employment policies and procedures were included. We saw the policies and procedures were updated.

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

There were clinical meetings held to meet staff learning needs and the practice development and progression. These were for all GPs and nurses and the practice manager also attended. They also considered the QOF outcomes.

Staff told us they had quarterly staff meetings and additional meetings if there were changes introduced in the practice. They said the meetings were open discussions and felt they were able to contribute. We looked at the records of some meetings and noted they were not available for all meetings.

Leadership, openness and transparency

There was a daily meeting scheduled for the GPs. There were quarterly meeting for the partner GPs and practice manager and quarterly clinical meetings.

We were shown the electronic staff handbook that was available to all staff. Staff we spoke with knew where to find these policies if required.

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

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

The practice gave patients the opportunity to participate in the 'friends and family test'. They could do this in the practice or through the practice website. We saw comments received by the practice that patients indicated could be made public. One patient referred to the speed with which telephone calls were answered, excellent phone back service and availability of same day appointments. Another patient referred to the GPs being friendly and professional.

The registered manager told us there were plans to invite patients to join a patient participation group.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training.

The registered manager told us about arrangements that had been made to have a consultant psychiatrist to talk with staff regarding suicide at one of the monthly meetings so they could increase their knowledge.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
	Regulation 15 HSCA 2008 (Regulated Activities) Regulations 2010 Safety and suitability of premises We found that the registered person had not protected people against the risk associated with unsafe or unsuitable premises. This was in breach of regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People who use services and others were not protected against the risks associated with unsafe or unsuitable premises because there was no health and safety policy or risk assessment to protect patients, staff and visitors to the practice.