Chipping Surgery

Quality Report

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Date of inspection visit: 21 January 2015
Date of publication: 09/07/2015

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 The Chipping Surgery on 21 January 2015. Overall the practice is rated as GOOD.

We found the practice to be good for providing responsive, effective, caring, services for older adults, families and children, patients with long term conditions, vulnerable patients, patients with mental health issues and patients who worked. It required improvement for providing safe services in regard of the use and management of medicines.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to medicines.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The practice provided general health advice including a sexual health support to young people living in the area and who may not have been registered with the practice.
- Some dispensed medicines were delivered to people's homes and there were local collection points in outlying villages.

The Provider MUST:

- Ensure that the storage of blank prescription prescriptions and dispensing of medicines meets legislative requirements and current practice guidance.

The provider SHOULD:

- Ensure there is a system to regularly review staff records to assure staff are appropriately prepared to undertake their role such as ensuring there are up to date records of staff continuing professional development and staff hepatitis B status.
- Ensure the infection control audit action plans are in place and monitored to ensure actions have been followed through.
- Ensure the procedure allowing practice staff authorised for access to the dispensary is based on a risk assessment.

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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, and overall appropriately reviewed and addressed. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. For example, not all prescriptions were signed before medicines were dispensed. On the day of the inspection staff were not able to locate two up to date patient group directions for the safe administration of immunisations and other medicines. The information regarding patient group directions was sent to us within a specified time and demonstrated the practice were using up to date directions. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the GP National Patients' Survey (2014) showed patients 94% of patients rated the practice very good or fairly good which was above the Clinical Commissioning Group average. Patients said all staff they were respectful, helpful and understanding and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw staff communicated with patients with patience, kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. Data from The GP National Patient Survey (2014) indicated 99% of respondents were satisfied or fairly satisfied with their last appointment. 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 was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and values. Staff were clear about the values 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. Overall there were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The provider was rated as good for this population group. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services. For example, in avoidance of admission to hospital and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Patients could have their medicines delivered to their home if they were not able to collect them.

People with long term conditions

Good

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

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

The provider was rated as good for caring for this population group. The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the

Summary of findings

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.

People whose circumstances may make them vulnerable

Good

The provider was rated as good for this population group. The practice had met all (100%) of the minimum Quality and Outcomes Framework (QOF) standards for monitoring patients with a learning disability including holding a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability and longer appointments were available.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good for this population group. The practice had met the Quality and Outcomes Framework (QOF) minimum standards (over 90%) for the monitoring of patients with dementia. The QOF data (27 of 28 patients on the mental health register) demonstrated people experiencing poor mental health had a care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

The practice had information in the practice for patients experiencing poor mental health such as MIND (a mental health charity), the Alzheimers Society and Gloucester Drug and Alcohol Services. There were on-line patient questionnaires on the practice website regarding alcohol intake and depression assessment.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with seven patients two of whom were from the patient participation group. We looked at 47 CQC patient comment cards, the GP National Patient Survey 2014/15 (published January 2015), the NHS choices website and the practice survey 2013/2014

Patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients were highly satisfied with the care and treatment received. Staff were described as helpful, caring and understanding. This was supported by feedback from the GP National Patient Survey 2014/15 which indicated 83% and 81% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. Additionally 94% of respondents described their experience of the practice as fairly good or very good. Further comments indicated 91% of patients said they would recommend the practice to family and friends.

Patient feedback showed patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. Feedback from the GP National Patient Survey 2014/15 indicated 76% of patients said the last GP they saw was good at involving them in decisions and 80% said the last nurse they saw was good at explaining tests and treatments. These results were comparable to the Gloucestershire Clinical Commissioning Group (GCCG) average. Patients felt their privacy and dignity were respected.

Feedback from the GP National Patient Survey 2014/15 indicated 99% of patients said their last appointment was convenient for them which was above the GCCG average. The practice patient survey 2013/2014 indicated that only 69% of patients said they could access an urgent appointment on the same day however, the practice had since responded to this by increasing the number of GP appointments and re-opening on a Wednesday afternoon. Patients' feedback on the day told us patients could normally access a day of need appointment.

Patients told us occasionally there was a wait of up to two weeks to see a GP of choice however; generally routine appointments were usually available in two to three days. This feedback was confirmed by the evidence we saw on the day of the inspection.

Two patients told us there were occasions when there was a wait after their appointment time. However, this was not supported by feedback from the GP National Patient Survey 2014/15 which indicated the average wait in the surgery to see the GP was five to15 minutes, less than the Gloucestershire CCG average.

Patient feedback indicated they were satisfied with the dispensary service.

Patients we spoke with on the day were not aware of the complaint process even though there was information available in the practice. They expressed confidence in the practice to address concerns when they were raised.

Patients told us they were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service MUST take to improve

- Ensure that the storage of blank prescription prescriptions and dispensing of medicines meets legislative requirements and current practice guidance.

Action the service SHOULD take to improve

- Ensure there is a system to regularly review staff records to assure staff are appropriately prepared to undertake their role such as ensuring there are up to date records of staff continuing professional development and staff hepatitis B status.
- Ensure the infection control audit action plans are in place and monitored to ensure actions have been followed through.

Summary of findings

- Ensure the procedure allowing practice staff authorised for access to the dispensary is based on a risk assessment.

Chipping Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a CQC pharmacist, nurse specialist advisor and practice manager specialist advisor.

Background to Chipping Surgery

As part of the inspection we visited the Chipping Surgery, Symn Lane, Wooton under Edge, Gloucestershire, GL12 7BD.

The Chipping Surgery is a small rural dispensing and teaching practice which provides primary care services to residents in the town of Wooton under Edge and surrounding villages. The practice has all patient services located on the ground floor of the building. The practice has a population of approximately 8,500 patients of which many are of working age.

The practice has two female and two male GP partners. They employ three salaried GPs, five nurses, four dispensary staff, a practice manager and reception/ administration staff. Most staff work part-time.

The practice is open five days of the week. Monday 8.30am – 7.30pm with an extended nurse clinic from 6.30 – 7.30pm, Tuesdays Thursday and Friday 7.30-8.20am and 8.30 – 6.30pm and Wednesdays 8.30am- 5.00pm. The practice has opted out of the Out of Hours primary care provision. This is provided by South West Ambulance Service Foundation Trust.

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

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 patients' needs?
- Is it well-led?

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

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

Detailed findings

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the Gloucestershire Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 21 Jan 2015. During the inspection we spoke with six GPs, three nursing staff, administration and reception staff. We spoke with seven patients who used the service. We looked at Care Quality Commission (CQC) patient comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as complaints received from patients. We saw evidence staff had acted appropriately in response to the alerts by contacting patients who had been prescribed medicines which had been recalled by the pharmaceutical company. Although there was evidence to demonstrate staff we spoke with had read the alerts there was not a formal system in place to monitor if staff had read the information.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. The practice utilised a computer software package which identified patients prescribed with specific medicines which may have put them at risk such as, warfarin (blood thinning) and methotrexate (treatment of arthritis) if they were not monitored regularly. GPs looked at the findings regularly and patients were reviewed if necessary.

Patient safety alerts, significant events and safeguarding concerns were a standing item on the weekly clinical practice meeting attended by the GPs and practice manager. The minutes of the meetings were available to staff as information via a shared folder on the computer and also discussed at team meetings. In addition patient safety alerts were emailed to staff as they were received by the practice.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were ten records of significant events that had occurred during 2014 and we were able to review these and there was evidence the practice had learned from these reviews. For example, three of these related to prescribing issues which had resulted in the development of protocols as further guidance for staff.

Significant events were reviewed at the weekly practice meeting. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

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 all staff had received relevant role specific safeguarding training. We asked members of medical, nursing and administrative staff about their most recent training. Staff told us they knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had dedicated GP leads in safeguarding vulnerable adults and children. They had been trained to an appropriate level. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients and their families on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans. There was evidence to demonstrate that meetings with the health visitors and other relevant agencies were taking place and staff from the multidisciplinary team told us there was consistent, collaborative working within the practice.

There were notices in all patient areas advising patients about requesting a chaperone (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All staff undertaking chaperone duties had the appropriate security checks and knowledge of the practice chaperone procedure.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We noted the

dispensary was not accessible by patients and the general public however, staff access to the dispensary (not the area where controlled medicines were kept) was not based on a risk assessment. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

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

Overall the repeat prescribing procedure protected patients from risk. Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. However, we found although the GPs regularly signed prescriptions before medicines were dispensed the system was not consistently adhered to and some medicines were dispensed before the prescription was signed. This was not in line with legal requirements. Storage and recording of blank prescription forms did not always follow the NHS Protect Security of Prescription Guidance. This resulted in an increased risk that the prescription pads could be accessed by unauthorised people.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly.

The practice had an established service for patients to pick up their dispensed prescriptions at locations in four different villages so that patients did not have to go to the practice. They also delivered medicines directly to patients' homes. They had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

We found on the inspection there were two patient group directions for immunisations which had not been replaced with the most up to date information (patient group directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. PGDs can only be used by nurses that have been trained, assessed as competent and authorised by the practice to use those specific PGDs). Staff were not able to locate the PGD on the day of the inspection. We also noted there was not a signed patient group direction for nurses to administer emergency medicines in the event of a foreseeable emergency such as anaphylaxis.

We were sent the up to date PGDs within the specified time frame following the inspection; these were in date and nurses had been authorised to administer the PGDs by a GP which was in line with legal requirements and national policy for the safe administration of PGD's. Staff told us they were up to date with immunisation training.

We saw there was a system in place for the management of high risk medicines which may put patients at risk such as methotrexate (for treatment of arthritis) and warfarin (used to thin blood), which included regular monitoring in line with national guidance. Evidence from medicines audits indicated that these medicines were regularly reviewed to ensure patients were prescribed the appropriate medicine such as changes from warfarin to other blood thinning agents. We were told there was a system to monitor and recall patients requiring a general medicines review with their GP. For example, when their medical condition was monitored and / or repeat prescription issues had reached their authorisation date.

We looked at prescribing data from the Quality and Outcomes Framework (QOF) and saw the practice was in line with the national prescribing pattern for antibiotics, hypnotics and anti-inflammatory medicines.

Cleanliness and infection control

The practice had processes to protect patients from the risk of infection. We observed the premises to be visibly clean

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

The practice had a lead for infection control who had completed an infection control audit in 2014. On the day of the inspection the documentation presented did not include an action plan for identified issues or concerns. Additionally it did not identify who was responsible for the corrective actions or dates for completion of identified areas for improvement. However, we noted the items identified as requiring attention on the audit such as posters regarding hand washing procedures had been completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. We saw all nursing staff had regular infection control updates in 2014.

Notices about hand hygiene techniques were displayed in treatment areas and staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Sharps disposal boxes were stored safely.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. Overall we found the monitoring, testing and maintenance of equipment was regularly carried out based on a risk assessment.

Staffing and recruitment

The practice had processes to enable the recruitment of appropriately qualified staff. There was a clear recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We looked at five staff files which contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We noted one member of staff did not have their hepatitis B immune status recorded in the practice records.

Staff told us about the arrangements for planning and monitoring the number of staff and skill mix needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

Identified risks for example, community nurse staffing levels and cover for on call shifts had been discussed at clinical meetings.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records we looked at showed with the exception of one person staff had received relevant training in basic life support in line with national guidance. Emergency equipment was available for example, oxygen and automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines were available in a number of secure areas of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We noted the emergency equipment and emergency drugs were not kept together to enable the efficiency of managing an emergency. However, when we asked members of staff, they all knew the location of this equipment and records confirmed that it was

Requires improvement

Are services safe?

checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient who had a serious fall and the practice had learned from this appropriately.

A business continuity plan was in place to deal with a range of emergencies that impacted on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used a range of interventions to promote 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 other research reports.

The use of guidance prompted clinical audit and reviews of clinical guidelines for example, the management of patients prescribed with anti-epileptic medicines. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the use of care pathways and care plans for patients with long term conditions such as heart and respiratory disease.

The practice had undertaken an audit of nurses' appointments over a four week period. The audit demonstrated that more time was required for certain consultations such as travel vaccinations and asthma reviews. More time was allocated and re-audited four weeks later to evaluate the results which demonstrated further time was required for certain practice nurse activities.

GPs told us they lead in specialist clinical areas such as respiratory disease and women's health. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Each of the practice nurses had a lead role in the management and support for long term conditions such as diabetes and respiratory conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We looked at data from the local Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

The practice used a risk stratification tool to identify their most vulnerable patients. Personalised care plans had been developed to enable the support and treatment for all of the 139 patients identified as at risk. Patients admitted to hospital were followed up on discharge within a specified period of time.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of cancer patients.

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

Management, monitoring and improving outcomes for people

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

The practice had completed nine clinical audits in 2014 one of which had made changes to treatment and then was repeated to ensure outcomes for patients had improved. The aim of the audit was to identify the number of patients who were taking medicines for an underactive thyroid whose blood hormone levels were showing signs of being over suppressed by the medicine. Following patient education regarding the benefits and risks of continuing with the medicine the audit was repeated. The second audit demonstrated a number of patients were no longer over suppressed having made changes to their medicines on the advice of the GP.

Another audit evaluated the coil fitting service. There was an additional aim to review the impact of undertaking biopsies of the lining of the womb on referrals to gynaecological services at the hospital. This audit demonstrated 11 of the 14 biopsies undertaken at the practice gave normal results. Three biopsies were inadequate samples however; the patients were able to have an ultrasound scan at the practice to investigate their

symptoms. The practice concluded from the audit results that referrals to hospital gynaecological services were reduced as a result of having the diagnostic services at the practice.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions e.g. diabetes and implementing preventative measures. The results are published annually) and performance against national screening programmes to monitor outcomes for patients. The practice had 98.7% achievement of all of the QOF minimum standards in 2013/2014 which was just above the Clinical Commissioning Group average.

There was a protocol for repeat prescribing which was in line with national guidance. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question. For example, the use of a particular type of insulin. Patients receiving the medicine were promptly identified and their medicine changed. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. Patients taking blood thinning medicines were able to have blood sample taken and tested at the practice. They were then able to commence a new medicine regimen promptly if their medicines dosage required adjustment.

The practice supported patients with long term conditions by offering advice and support through specialist clinics, screening and evidence based information. Routine health checks were completed for long-term conditions such as diabetes and respiratory conditions. QOF data 2013/2014 demonstrated 78.8 % of patients with asthma (above the CCG average) and 90.4% of patients with chronic obstructive airways disease had a review in the preceding 12 months. All patients identified as at risk of unplanned admissions to hospital (139 patients) had care plans to support and manage their treatment to enable them to remain at home. Care management was co-ordinated through multi-professional meetings with health and care professionals involved in their care.

The practice had implemented the Gold Standards Framework for end of life care. It had a palliative care register and met and worked with other health care professionals monthly to discuss the care and support needs of patients and their families.

The practice supported patients experiencing poor mental health by regular monitoring of their treatment and support needs. For example, 91.7% (QOF 2013/2014) of patients with serious mental health issues had a care plan documented in their records. Monitoring of patients wellbeing was above average for the CCG.

There were clinical protocols and policies available as guidance for staff to manage patients' treatment effectively.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records. Staff updated the practice staff training records and provided evidence of continuing professional development such as attendance at courses. Overall staff training records were generally well maintained and the records we looked at demonstrated that staff had attended mandatory training such as annual basic life support, health and safety, safeguarding and infection control updates. Staff personal, professional portfolios available on the day demonstrated they had completed the necessary continuing professional development (CPD) training to undertake their role. We noted the practice did not keep a copy of all of the staff CPD evidence in the practice files as an additional means to monitor that staff were appropriately trained for their job roles and responsibilities.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. Role responsibilities included extended roles such as asthma and diabetes reviews and insulin initiation (supporting patient transition from oral diabetic medicines to insulin treatment).

We noted a good skill mix among the doctors with a number having additional training such as minor surgery and endometrial biopsies and interests in long term conditions and women's health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every

five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We were told all staff received annual appraisals that reviewed staff training which included the mandatory training undertaken. Appraisal dates were set based on the date staff commenced at the practice and were undertaken by respective team leaders.

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. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for an enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) to support frail patients to avoid admission to hospital and stay at home. The GPs worked with the multidisciplinary team to develop and review patient care plans to meet the changing needs of these patients. There was a process in place to follow up patients discharged from hospital within a specified period of time.

The practice worked with a range of other agencies to support vulnerable patients and those at risk. The practice held monthly, minuted multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, health visitors, and palliative care nurses. Decisions about care planning were documented in a shared care record.

Members of the multidisciplinary team (MDT) we spoke with told us the GPs were accessible and communicated promptly when they had concerns or information regarding patients at risk and their families. For example, women reported to have a history of domestic violence. This was confirmed by written communications that had taken place.

The GPs told us they worked in partnership with local mental health services and regularly referred patients to local psychological support services.

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 and care plans to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, for example, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice was also 'live' in the implementation of the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

Consent to care and treatment

We found that GPs and nurses applied the principles of the Mental Capacity Act 2005 and the Children Acts 1989 and 2004 to their practice area.

Patients with a learning disability and those with dementia were supported to make decisions about their care and treatment. When interviewed, staff gave examples of how to enable patients to make informed decisions. For example, giving more time during appointments and checking patients understood the treatment they were to have by explaining in their own words. Staff understood the principle of acting in a patient's best interest. We saw from a significant event review the GPs were aware of the impact of diminished competence and their responsibilities in ensuring patients were appropriately assessed.

Overall, nursing staff demonstrated an understanding of Gillick competencies (These are used to help assess

Good

Are services effective?

(for example, treatment is effective)

whether a child has the maturity to make their own decisions and to understand the implications of those decisions) and a duty of confidentiality to children and young adults.

The practice had a process to obtain consent from patients prior to minor surgery undertaken at the surgery. Records confirmed the process was consistently followed.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice had systems to monitor the health requirements of the practice population. For example, NHS Health Checks offered to all its patients aged 40 to 75 years. The practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse.

The practice had strategies to enable patients to take responsibility for their own health when they were able. There was a range of health promotion information in the practice and links on the practice website for all patient groups. Patients were offered support for smoking cessation and weight management through clinics offered at the practice.

The practice offered a confidential 'teenage walk in health clinic'. We had noted the practice was located on a road near the local school and the clinic information was clearly visible to students passing by. The weekly clinic offered health advice for young people such as bullying, sexual health and eating disorders and was available to all teenagers including those not registered as patients at the practice. During 2014 24 young people attended the clinic. Free screening kits for chlamydia (a sexually transmitted disease) were also available for under 25's.

The practice's performance for cervical smear uptake was 81.8%, (National Intelligence Cancer Network 2014) which was above the Clinical Commissioning Group (CCG) average. Performance for breast and bowel cancer screening was similar to the average for the CCG (National Cancer Intelligence Network 2014 81.6% and 69.6 % respectively).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was equal or above average for the CCG. There was a protocol to follow up non-attenders.

Patients who did not attend for health checks, reviews or follow up appointments were contacted to arrange for another appointment where nurses or GPs were concerned about their wellbeing.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This was data from the GP National Patient Survey (2014/15), feedback from Care Quality Commission (CQC) patient comment cards and information from the practice survey 2013/2014.

We received 47 completed CQC patient feedback cards and spoke to seven patients (two of whom were from the Patient Participation Group). Patient feedback about staff was positive. They were described as caring, understanding and helpful. This was supported by feedback from the GP National Patient Survey which indicated 83% and 81% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. Additionally 94% of respondents described their experience of the practice as fairly good or very good with a further 91% of patients saying they would recommend the practice to family and friends. Patients we spoke with felt their privacy and dignity were respected. We observed a number of examples of patient, respectful and kind caring interactions with patients.

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

We saw that staff was careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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 GP National Patient Survey (2013/14) showed 86% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were similar to the Gloucester Clinical Commissioning Group (GCCG) average.

Patients we spoke with on the day of our inspection told us their 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 usually had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room, and patient website directed patients to a range of support groups and organisations. Patients experiencing poor mental health could see a mental health nurse who held a monthly clinic at the practice.

The practice's computer system alerted GPs if a patient was also a carer. We saw there was information in the practice and on the practice website available to enable carers to understand the various avenues of support available to them. Carers were contacted invite them for the annual flu injection.

Staff told us that if families had suffered bereavement their GP would contact them. A note was placed on bereaved carers electronic records to inform staff of their bereavement. In addition one GP gave patients and their families a mobile phone number to access additional support more readily.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to the needs of the practice population and had systems in place to maintain the level of service provided. The practice had a population of 8,500 of which many were of working age. The area is one of the least deprived in the country.

Patients were able to access later evening and earlier morning appointments to fit in around work commitments. Evidence demonstrated patients were easily able to get urgent and routine appointments. The GPs offered telephone consultations in every surgery and communicated via SMS text messaging where the patient chose. Patients were able to remain updated with practice news via a newsletter, and social media such as Twitter and Facebook.

Patients had access to specific treatment and support at the practice rather than having to attend hospital. For example, spirometry (measures breathing capacity) for patients with chronic lung disease, insulin initiation for patients transferring from oral medicines to insulin for diabetes management and blood tests for blood clotting times. In addition the practice offered endometrial (womb lining) biopsy and ultrasound as an aid to diagnosis and minor surgery.

The practice provided dispensary services for approximately 60 % of practice patients. Feedback from patients indicated they were satisfied with the service. In addition medicines were delivered to six venues in outlying villages and also to patients' homes.

Systems were in place for identifying and following-up children who were at risk. There were formal arrangements in place to liaise with health visitors and midwives when there were concerns about patients and families at risk. The midwives and health visitors were based at the clinic.

Immunisation rates were generally equal to or above the Gloucestershire Clinical Commissioning Group (GCCG) average for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. GPs offered a confidential 'teenage walk in clinic 'once per week for support and advice on a range of issues. Patients under the age of 25 had access to screening for chlamydia (a sexually transmitted disease) without having to see a GP first.

Patients with a range of physical and mental health conditions had access to regular health reviews, screening and monitoring.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice held a register of patients with learning disabilities and patients with dementia.

Longer appointments for patients with learning disabilities could be arranged in recognition of the time needed to involve patients in their care and treatment. Patients over the age of 75years had a named GP to enable continuity of care.

Most patient services were situated on the ground floor of the building. There was not a lift in the building however, patients not able to access the first floor had consultations arranged in ground floor rooms. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was a separate waiting area for antenatal services away from the main patient waiting area. There was an induction hearing loop for patients with hearing impairment. Accessible toilet facilities were available for all patients attending the practice, baby changing facilities were also provided.

The practice had access to online and telephone translation services for patients where English was not the patient's first language.

Access to the service

The practice was open Tuesdays, Thursdays and Fridays 7:30am – 8:20am and 8:30am – 6:30pm. Mondays the practice opened from 8:30am – 7:30pm with extended nurse clinic until 7:30pm and Wednesdays 8:30am – 5pm. The dispensary was open from 8:30am – 6:30pm each weekday with the exception of Wednesdays when it closed at 5pm.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were able to book and cancel appointments in person, by telephone and online. Repeat prescriptions could be requested online, post or in person. GP appointments were confirmed by text with patient permission.

Patient feedback indicated they were generally satisfied with the appointments system. Information from The GP National Patient Survey (2014) indicated 99% of respondents were satisfied or fairly satisfied with their last appointment (above the CCG average). The practice patient survey 2013/2014 indicated that only 69% of patients said they could access an urgent appointment on the same day however the practice had since responded to this by increasing the number of GP appointments and re-opening on a Wednesday afternoon. Patients' feedback on the day told us patients could normally access a day of need appointment.

Some patients told us there was occasionally a wait of up to two weeks to see a GP of choice however, generally routine appointments were usually available in two to three days. This was confirmed by the practice patient survey 2013/2014 which demonstrated 67 of 76 respondents saw a GP within two days and 72 of the 79 respondents strongly agreed or agreed they could see a doctor of choice within five working days. This availability of appointments was confirmed by the evidence we saw on the day of the inspection with a number of routine appointments available.

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

The practice supported three nursing homes and a named GP generally visited the homes every two weeks. Home visits were arranged at the beginning of the day to ensure any potential admissions to hospital or access to services were managed in a timely way.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available to help patients understand the complaints system. Although patients we spoke with were not aware of the process to follow if they wished to make a complaint they said they felt able to report concerns and had confidence the practice would manage them appropriately. None of the patients we spoke with on the day of the inspection had made a complaint about the practice.

The practice reviewed complaints at weekly practice meetings and team meetings. There were five complaints recorded in 2014. The records were comprehensively documented and demonstrated learning had taken place. We saw an example of how a patient had complained about wheelchair access. A note was placed on their patient record to ensure appointments were made for a ground floor consultation.

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 and values and were aware of future challenges to the practice for example the appropriateness of the building and an expanding patient population. The main values were to deliver high quality care and promote good outcomes for patients. We found these values were printed in the practice information leaflet as a patient charter. They emphasised a patient centred approach to care and the standards of service that could be expected. We saw and read of examples of how these values were reflected in practice.

Governance arrangements GPs

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a nurse with lead responsibilities for infection control and GPs had lead responsibilities for safeguarding and information governance. We were told the GPs met informally on a daily basis to peer review patient referrals and immediate patient concerns. In addition they met weekly with the practice manager and other staff as necessary to discuss practice issues for example, significant events, patient safety alerts and complaints. with partners meetings scheduled every two months. The practice held six monthly practice meetings for all staff. Minutes from all meetings were available for all staff to access in a shared folder on the computer.

The practice had policies and procedures in place for staff to govern activity and these were available to staff. We looked at a range of policies in recruitment, safeguarding and dispensary practice. These were up to date and there was a scheduled review date.

The practice had schedules to assess and update practice risk assessments and had appropriate contractors to manage calibration and testing. Overall, the monitoring of external contract work was consistent such as cleaning and waste disposal. Calibration of two pieces of equipment was overdue. The practice manager was aware of this and had already made arrangements to address this. However, there were areas of medicines management such as the security of prescription pads and the signing of prescriptions before medicines were dispensed to patients which were not in line with national guidance or legislation. Staff were not able to demonstrate on the day of the inspection they were working from up to date patient group directions.

Significant event and written complaints records were comprehensively completed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing above national standards.

The practice had completed nine clinical audits, each with one full audit cycle to demonstrate the effectiveness of the changes made. For example, the management of patients taking medicines to manage a thyroid (a gland) condition and an evaluation of the coil fitting service and endometrial biopsy service which demonstrated an impact on referrals to hospital.

Leadership, openness and transparency

We saw from minutes that individual team meetings were held monthly. Staff we spoke with told us that there was an open culture within the practice and they enjoyed working there. We also noted there had been team some away days.

Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns. They were happy to raise issues for meetings and were well informed of practice issues via individual monthly team meetings and the six monthly practice meetings.

Staff had access to on-going professional development opportunities and regular appraisal.

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

The practice had gathered feedback from patients through patient surveys, complaints and the patient participation group. The practice had an active patient participation group (PPG) of 15 participants which met regularly. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. They demonstrated the practice had responded to comments about not always being able to access on the day of need appointments. The

Are services well-led?

Good

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

practice had responded to this by increasing a further four GP sessions and re-opening on a Wednesday afternoon. In addition on recommendation from the PPG the practice had staff photographs on the website.

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

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated overall the management team led through learning and improvement. For example, there were a range of audits, completed audit cycles and some in the process of re-audit. Records of meetings, significant events and complaints were available as a resource for staff.

We saw evidence of changes to practice resulting from learning from incidents and significant events. For example, re-opening the surgery on a Wednesday afternoon rather than using the Out of Hours service.

Staff told us and training records confirmed staff were able to remain updated with mandatory training requirements. We saw continuing professional development opportunities were supported. Staff files we looked at demonstrated annual appraisal took place which included a personal development plan.

The practice was a training practice for foundation year two doctors (newly qualified doctors undertaking further training).

New staff were supported via an induction programme and specific support to orientate and train them for their role.

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
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines We found the registered person had not protected people against the risk of unsafe medicines practice. This was a breach of regulation Regulation13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. People were not protected against the risk of unsafe medicines practice because prescriptions were not consistently signed by GPs before medicines were dispensed. Blank prescriptions were not consistently stored in line with best practice.