The Three Shires Medical Practice - Wick

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at each of the four surgeries that form The Three Shires Medical Practice over three consecutive days. We visited The Three Shires Medical Practice – Wick on 10 June 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available 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.

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

Importantly the provider should:

- Consider the use of an effective infection control tool that covers all aspects of prevention and control of infection.
- Implement a system to ensure a formal audit cycle is in place.

Summary of findings

- Develop a protocol for the completion of care plans so there is evidence of patient involvement and all areas of the plans are completed and reviewed.

Professor Steve Field CBE FRCP FFPH FRCGP
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Whilst the practice carried out audits there was no formal system for maintaining an audit cycle. The infection control audit was lacking in some areas of infection prevention and control.

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 the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. However, there was no protocol for ensuring care plans were fully completed, reviewed or had evidence of patient involvement. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the practices vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was virtual however the practice manager was seeking to develop a formal PPG. Staff had received inductions, regular performance reviews and attended staff meetings.

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, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

Multi-disciplinary meetings were held to maintain and review care plans for patients over 75 years. These involved the coordination of care between physiotherapy, occupational therapy and pharmacy services along with the involvement of the community matron, nurses, social services and GPs.

The practice provided a home visiting service to a patient in a care home with nursing.

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 these patients 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.

Patients with long term conditions were re-called for appointments and follow up for monitoring and sign-posting to other services. The recalls were completed following searches of the computer based patient records system. Reminders were added to prescriptions or provided by telephone call and by letter.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people

Summary of findings

were treated in an age-appropriate way and were recognised as individuals, and we observed evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

We saw positive examples of joint working with health visitors. There was a health visitor clinic every four weeks in the practice. The practice liaised with health visitors and social services when there were child protection concerns.

Working age people (including those recently retired and students)

Good

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

The practice offered telephone appointments at pre-determined times for informal healthcare reviews so patients could speak with a GP about their health needs and receive treatment at a time that was convenient to them.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice liaised with community paediatricians, health visitors, physiotherapists and occupational therapists working with children with learning disabilities or other special needs. The practice provided a home visiting service to a local care home for patients with learning disabilities.

People experiencing poor mental health (including people with dementia)

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

Summary of findings

practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia. It carried out advance care planning for patients living with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

The practice had signed up for the Directed Enhanced Services (DES) for dementia screening and provided initial diagnostic testing and investigations including referral to memory services, if appropriate. It put 'flags' on patient's records if they were living with dementia so they could be easily identified by staff supporting them.

Summary of findings

What people who use the service say

We spoke with seven patients. They told us they were happy with the service they received and had never had cause for complaints. They spoke about the cleanliness of the practice and friendliness of the staff.

One patient told us how they had been given access to a room to feed her baby and how much they appreciated this.

A patient told us it helpful their GP remembered their medical history and they did not have to keep repeating it.

Patients told us about the medicines review reminders that were attached to repeat prescriptions. One patient told us about a delayed diagnosis in the past and another spoke about how their two week cancer referral had been efficient.

We contacted the manager of a local care home with nursing. The manager told us they only had one resident who was a patient at the surgery. They said they had always had excellent service from the practice.

Areas for improvement

Action the service SHOULD take to improve

Consider the use of an effective infection control tool that covers all aspects of prevention and control of infection.

Implement a system to ensure a formal audit cycle is in place.

Develop a protocol for the completion of care plans so there is evidence of patient involvement and all areas of the plans are completed and reviewed.

The Three Shires Medical Practice - Wick

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 nurse, specialist advisor.

The same team inspected the four surgeries that form The Three Shires Medical Practice on three consecutive days, 9th, 10th and 11th June 2015.

Background to The Three Shires Medical Practice - Wick

The Three Shires Medical Practice is a partnership of five GPs. They employ two salaried GPs and collectively the whole time equivalent of GPs is 5.5 full time equivalent (FTE) employees. The practice also employs two nurse practitioners and five other nurses along with phlebotomy, reception, administrative and managerial staff.

The practice provides services in rural areas of South Gloucestershire and Wiltshire from four surgeries, each of which are registered with the Care Quality Commission.

The surgeries are at:

35 High Street, Colerne, Wiltshire, SN14 8DD

2 Back Lane, Marshfield, South Gloucestershire, SN14 8NQ

12 Becket Court, Pucklechurch, South Gloucestershire, BS16 9QG

111 High Street, Wick, South Gloucestershire, BS30 5QQ

We inspected the four services over three consecutive days and have reported on each service separately, as required.

Overall, The Three Shires Medical Practice has a patient list size of a total 9,170 patients and patients can use any of the surgeries. The practice is a member of the South Gloucestershire Clinical Commissioning Group (CCG).

The Three Shires Medical Practice, Wick, has approximately 2610 patients on its list and provides a service to those who live in small villages in the vicinity including Abson and Doynton. Some patients commute into nearby Bath and Bristol. There is a sheltered housing complex in Wick to which the surgery provides a service to patients who live there.

The practice is open from 8.30 am Monday to Friday and remains open until 6.00 pm on Tuesday, Thursday and Friday each week. It has extended opening until 6.30 pm on Mondays and closes at 5.30 pm on Wednesday.

Fourof the GPs have additional qualifications in obstetrics, gynaecology and family planning.

The Three Shires Medical Practice evolved from four GPs working single handed and all practices have medicines dispensaries. The practice catchment area is 100 square miles and whilst patients can be seen in any of the surgeries they tend to see the GP near to where they live.

The practice holds a general medical services (GMS) contract and a range of other directed enhanced services (DES). DES are services which require an enhanced level of service provision above what is required under core GMS contracts. The practices DES included those related to facilitating timely diagnosis and support for patients with dementia and offering annual health checks for patients with learning disabilities.

Detailed findings

The practice is registered with the Dispensing Practice Quality Scheme and is inspected annually.

For patients who live in South Gloucestershire the practice contracts it's Out Of Hours service with Brisdoc and for those who live in Wiltshire the service is provided by Wiltshire Medical Services.

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We contacted South Gloucestershire Clinical Commissioning Group and NHS England area team. We also contacted South Gloucestershire Healthwatch. They had no concerns about the practice.

We carried out an announced visit on 10 June 2015. During our visit we spoke with a range of six staff including GPs, the practice manager and surgery manager, nurses and administrative staff. We spoke with six patients who used the service. We observed how people were being cared for and talked with family members and reviewed records. We reviewed five Care Quality Commission comment cards where patients shared their views and experiences of the service.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we saw the report of a significant event where two patients were prescribed the wrong medicines because the two patient's records were 'open' at the same time. The learning points for staff were to be aware when multiple records were open and for GPs to check patient details before signing the prescription.

We were told significant events meetings were held every two months however there were no records of the meetings. We saw a summary of significant events that recorded the date of the meeting when they were discussed, the nature of the event, learning points and actions. 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. We reviewed a summary of 12 significant events that had occurred during the last year and saw this system was followed appropriately. A dedicated meeting was held every two months to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

There was a robust system for national patient safety alerts from the Medicines and Healthcare Products Regulatory Agency (MHRA) to be disseminated to staff. The prescribing medicines management pharmacist met with the GPs every two months to ensure they were up to date with current guidance. Alerts were placed within the electronic records system for GPs to change medicines when repeat prescribing.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There was a GP who took the lead for safeguarding children and vulnerable adults. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. They had been in post three months andtold us they attended the quarterly meetings organised by South Gloucestershire Clinical Commissioning Group (CCG) for practice leads.

We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies.

The practice maintained a register of children at risk, those with a protection plan and vulnerable adults. There were flags on the patient record to alert staff the patient was on the register.

There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. We were given an example of where a GP attended a case conference and was able to contribute in discussions in respect of their actions in line with their role and responsibilities.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed.

Staff had completed 'identification and referral to improve safety' training in domestic violence provided jointly by Next Link domestic abuse support services for women and the South Gloucestershire Partnership Against Domestic Abuse.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure).

All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had not undertaken training and did not have Disclosure and Barring Service (DBS) checks however, we saw risk assessments had been completed. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). The managing partner told us arrangements had been made for key reception staff to undertake chaperone training.

Medicines management

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice had clear systems in place to monitor the prescribing of controlled drugs (CD). They carried out regular audits of CD prescribing. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

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.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in June 2015. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a Patient Specific Direction from the prescriber.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure.

Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

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 had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice had a robust system for checking the dispensed medicines and these were seen by a GP on all occasions. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Good

Are services safe?

Cleanliness and infection control

The arrangements for infection control were included in the clinical governance policy. There was also a specific policy for infection control however, it did not identify the infection control lead within the practice.

The 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.

Staff completed on-line training provided by Avon Local Medical Committee in infection prevention and control.

There was a policy for needle stick injury with a flow chart for actions for staff to take if they sustained such an injury. However, the action described in the flow chart was not what we were told by a member of staff had happened when they sustained an injury. The practice manager sought immediate advice from the South Gloucestershire Clinical Commissioning Group (CCG) to ensure the practice followed best practice guidance. The practice manager confirmed they had removed conflicting advice and ensured the procedure to follow with contact details were displayed in rooms where blood samples, vaccines and other injections occurred.

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.

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

There was no infection control audit for the consultation room. The examination couch was stained and the leather covering on the desk was lifting exposing untreated wood. We showed this to the nurse who told us she would carry out a full audit of the building and would ensure any action required would be undertaken as deemed appropriate.

The practice had recognised and assessed its processes for testing for legionella. We saw evidence to show the practice had booked an appointment for risk assessment for legionella. The practice would then make a decision about whether routine legionella testing was required or if a further risk assessment was more appropriate.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, weighing scales, spirometers, pulse oximeter, doppler, defibrillator and refrigerator took place on 22 April 2015.The practice had received a report from the contractor to indicate the equipment used were all satisfactory.

Staffing and recruitment

The practice human resources policy outlined the procedures to be followed when recruiting, selecting and retaining staff. The recruitment of staff involved checking identity and right to work, qualification and registration checks and obtaining references. In addition it referred to following the code of practice to ensure compliance with disclosure and barring service checks (DBS) for staff. The practice manager told us reception staff had been risk assessed and it was concluded they did not need DBS checks however, the managing partner informed us they would be carrying out checks on these staff.

We looked at a random selection of staff files across all surgeries. We found each to have a job description and person specification. There were offers of employment and contracts. We noted applications in the form of curriculum vitae (CV), references had been obtained and registration and immunisation status was checked where appropriate.

A newly appointed member of the staff team told us about their initial induction, meeting with the practice manager and shadowing other staff. They told us about their further induction and training that was planned. We saw induction training records in staff files.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that

Good

Are services safe?

enough staff were on duty. Staff covered shifts in any of the four surgeries operating as the Three Shires Medical Practice. 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. The practice manager told us that to maintain sufficient staffing levels and skill mix they considered patient waiting times and spoke with the GPs.

In order to maintain GP cover at all times, locum GPs were used. We saw that before they commenced working in the practice they provided evidence of their identity, DBS check, registration with the General Medical Council and indemnity insurance. The practice obtained two written references.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

The practice also had a health and safety policy which included information relating to workplace health and safety, fire prevention and fire-fighting, control of substances hazardous to health and risk assessment. Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Staff records showed that all staff had received training in basic life support.

The emergency equipment was checked on a daily basis. We saw oxygen was in date and all of the medicines recommended by the Resuscitation Council UK were in place and in date.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included access to premises, computer system, essential services and supplies and unplanned sickness. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

The practice had a risk management policy and carried out relevant risk assessments including a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

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 discussed with a GP how clinical guidelines were received into the practice. They told us this was downloaded from the website, was up to date and effective. GPs we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out assessments which covered all health needs and were in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

GPs told us they did not specialise in particular clinical areas except where they had additional diplomas in family planning and obstetrics. Nurses did and told us about the clinics they ran for patients with long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital.

We looked at four patient care plans across two of the surgeries and saw they were being developed and regarded as work in process by the practice. We saw some gaps in these records. For example, in one patient's care plan there was no indication it had been updated although they had recent blood tests. For another patient, receiving palliative care and at risk of re-admission to hospital, there was no next of kin shown, the person had not been asked about resuscitation or indicated their preferred place of death. Care plans did not record patient involvement. The practice told us they would be updating these patient records as a matter of priority.

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

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 data collection exercises and audits.

The practice showed us audits that had been undertaken in the last two years. Five of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit such as, the dosette box dispensing audit.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 98% of the total QOF target in 2014, which was above the national average of 94%. For example, the practices performance for diabetes related indicators was better than the national average with the exception of the number of patients with diabetes who had a foot examination and a cholesterol check which was marginally lower. The percentage of patients with a fragility fracture on 1 April 2012 who were being treated with a bone sparing agent was 100% for 2013/2014 compared to the national average of 81%. Similarly the percentage of patients with atrial fibrillation who were being treated with anti-coagulation medicine therapy or anti-platelet therapy was 100% for the same period compared to the national average of 98%.

Good

Are services effective?

(for example, treatment is effective)

The practice was aware of all the areas where performance was not in line with national or CCG figures and discussed these at partners meetings.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with learning disabilities and patients living with dementia. Structured annual reviews were also undertaken for people with long term conditions including patients with diabetes, heart failure and chronic obstructive pulmonary disease (CPOD).

The practice had a palliative care register and because numbers were low held ad-hoc multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. We saw benchmarking data showed the practice position in relation to antibiotic prescribing compared positively to other practices.

The practice provided a useful pregnancy care planner and patients who were pregnant were given 'The pregnancy Book'. It referred to conception, pregnancy and labour and mother and baby along with, general pregnancy topics such as feelings, relationships and rights.

There was information on the practice web-site relating to the schedule for children's immunisations that outlined when the child should be immunised, diseases they would be protected against and the vaccine given.

Since September 2008 there has been a national programme to vaccinate girls aged 12-13 years against human papilloma virus (HPV). The HPV can cause cervical cancer and the practice provided information about this through its web-site to help patients understanding and provided the vaccination.

Effective staffing

The practice human resources policy described the arrangements for the supervision of clinical staff along with, training and development.

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with completing mandatory courses such as annual basic life support, fire safety awareness and moving and handling.

Those with extended roles for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. Immunisation updates had been completed.

We noted a good skill mix among the GPs with two having additional diplomas in sexual and reproductive medicine and two with diplomas in obstetrics and gynaecology.

All GPs were up to date with their yearly continuing professional development requirements and had five days protected study leave each year. They had all either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals. The policy indicated this should be in the form of an 'annual structured formal dialogue'. We looked at appraisal documentation and saw it contained notes from the meeting between the staff member and their supervisor along with an action plan and record of a review of policies and competencies.

Action plans identified further training needs. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, a National Vocational Qualification in prescribing.

Practice nurses and other staff had job descriptions outlining their roles and responsibilities and set out the requirements of the position. For example, it was a

Good

Are services effective?

(for example, treatment is effective)

requirement for the appointment of a nurse practitioner they had to provide evidence that they were trained appropriately to fulfil their duties, as specified by the Nursing and Midwifery Council (NMC).

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 practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of Hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were similar to the national average at 14%. The practice was commissioned for the unplanned admissions enhanced service. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). Actions arising from hospital discharge summaries, such as changes to medicines were followed up by the GP when they read the summary. The practice GPs did not routinely contact patients when they were discharged from hospital however, district nurses made home visits and GPs visited if needed.

The practice held weekly multi-disciplinary team meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs and children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. We noted some care plans were not complete and the practice recognised this was a work in progress.

We met with a member of the community district nursing team. They told us they were provided with a room at the Pucklechurch surgery from which to provide a service and had worked with The Three Shires Medical Practice for 17 years. They spoke about good communication with the practice and close working.

Information sharing

There were 'How we handle information about you' leaflets in the reception and waiting area. The patient confidentiality policy outlined how other local health services could access information about patients through the summary care record in the event of emergency care. The summary care record held information about the medicines a patient was prescribed and allergies along with adverse reactions to medicines so that those caring for the patient could do so safely. The policy outlined how patients could choose for this information not to be shared.

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and Out-Of-Hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice had also signed up to 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).

Referrals to secondary care were usually through the NHS e-Referral Service (formerly the 'choose and book' system which ceased to be used in June 2015) electronic system and the practice used Clinical Commissioning Group referral tools for any 'two week wait' cancer referrals.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software

Good

Are services effective?

(for example, treatment is effective)

enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified by sharing them with practice staff.

Consent to care and treatment

There was an identified lead GP with responsibility for ensuring the Mental Capacity Act 2005 was implemented in the practice. All of the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Staff told us they would document if a patient declined treatment along with the options given to them.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. These included the involvement of an advocate for one patient, and making a positive decision to proceed with a health test that revealed an abnormal result. Another example referred to was when a decision was made not to proceed as the patient would not cooperate and refuse to be examined.

GPs demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). However, not all nursing staff were aware that if a child under the age of 13 years requested contraceptive treatment they should be referred to social services as a potential child protection issue. The managing partner told us they would ensure all clinical staff were made aware of this.

Health promotion and prevention

There was information on the practice website regarding new patient registration. All new patients were offered a health check with a member of the healthcare team to ensure any required tests were up to date and to ensure the practice had an accurate note of any repeat medicines prescribed. Patients could print a registration form and complete it before going to the surgery.

The practice web-site gave access to the Royal College of General Practitioners guide to services on offer at a GP practice. It also signposted patients to where they could gain advice for self-help in relation to a range of health and well-being issues including, migraine, sinusitis and coughs. The web-site contained information about getting the right treatment and described how, in addition to self-help, patients could seek advice from their local pharmacist, NHS walk-in Centres and accident and emergency departments. The information included details of when it would be appropriate to choose one of these services.

The practice's performance for the cervical screening programme was 82%, which was to the same as the national average of almost 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Performance for 2013/2014 was above average for the majority of childhood immunisations where comparative data was available. Childhood immunisation rates for the vaccinations given to under twos ranged from 93% to 100% and five year olds from 86% to 100%. These were comparable to the South Gloucestershire Clinical Commissioning Group members' averages. Flu vaccination rates for the over 65s were 75%, and at risk groups 54%. These were similar to national averages.

We saw a range of leaflets in the waiting area including some related to dementia awareness, eating well, allergies, cancer and help with NHS costs. We also noted there was information for carer's.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey for 2014 and a survey which obtained feedback from 29 patients undertaken by the practice.

The evidence from these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with GPs and nurses. For example, 94% patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 87% and national average of 87%. 93% patients who responded said the GP was good at treating them with care and concern compared to the CCG average of 83% and national average of 82%. 95% patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 92%.

The patient survey carried out in May 2015 asked patient questions about a range of issues relating to the practice including, access to appointments, cleanliness and helpfulness of the receptionists. Patients who responded to the survey indicated the practice was "excellent" at putting patients at ease, politeness, listening and honesty along with giving patients enough time. They indicated the practice could do better at improving access to telephone appointments and extending on-line access to appointments. The practice action plan indicated there would be an increase in telephone appointments in the afternoon.

We looked at the NHS Choices website that enabled patients to rate and review the NHS services they received. There were two ratings and one recent review that was critical about parking availability and access to appointments. The managing partner had responded to the criticism.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 10 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with seven patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. There was a sign at the reception desk politely asking patients to stand back until it was their turn to speak with the receptionist.

Additionally, 88% patients said they found the receptionists at the practice helpful compared to the CCG average of 87% and national average of almost 87%.

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

A local MP conducted a health and social care survey in March 2013 across their constituency that attracted over 6,000 replies and was reported in the local press. The Three Shires Medical Practice was rated highly.

The practice, along with the practices at Marshfield and Pucklechurch achieved 80% satisfaction from respondents who attended the practices rating them positively.

The practice confidentiality policy stated the practice respected patient's right to privacy and confirmed that it would keep all their information confidential and secure.

There was guidance on the practice web-site for when bereavement occurred giving practical advice for what to do at that time.

Good

Are services caring?

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed for 2014 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: 83% patients said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 82% and national average of 81%. Similarly, 80% patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 73% and national average of 75%.

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.

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

There was a clear statement on the practice website stating the practice's zero tolerance for abusive behaviour.

Patient/carer support to cope emotionally with care and treatment

The practice website had information for carers. It asked patients to let the practice know if they cared for someone as they may be able to support them. It drew attention to the Bristol Carers Support Centre and gave the telephone number for the Bristol and South Gloucestershire Carers Line. The website had a link to the Carers Support Centre website where there were videos and documents to support carers.

The practice sometimes referred patients to CRUSE following a bereavement although most support was provided by the patient's GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, because of their rural locations all of the surgeries in the practice dispensed medicines which patients told us they appreciated.

Tackling inequity and promoting equality

The practice web-site had the facility for people to read information produced by the NHS in a range of languages. The fact sheets explained the role of UK health services and were aimed at newly-arrived individuals seeking asylum in the UK.

There was a small car park to the front of the surgery with disabled parking and level access into the building and inside the practice.

Access to the service

The practice website listed the opening times and arrangements for home visits and what to do Out Of Hours in an emergency. There was the facility for patients to make an appointment and order prescriptions on-line. In addition there was a list of the clinics for chronic disease management and other services. These included family planning, maternity services, minor surgery and lifestyle advice including smoking cessation.

The surgery had three consulting rooms andone treatment room. There was a patient waiting area and reception all of which had level access.

The practice was open from 8.30 am Monday to Friday and remains open until 6.00 pm on Tuesday, Thursday and Friday each week. It had extended opening until 6.30 pm on Mondays and closed at 5.30 pm on Wednesday.

The practice contracted it's Out Of Hours service with Brisdoc.

Listening and learning from concerns and complaints

The practice complaints procedure outlined how if patients wanted to complain about any aspect of the service they should speak with their GP or contact the practice manager who was based at the Marshfield surgery. The procedure stated any complaint would be acknowledged within two working days and the practice aimed to have looked into the complaint within 10 working days.

The procedure listed the actions the practice would take to discover what happened and what went wrong making it possible for the patient to discuss the problem with those concerned. It also stated the patient would receive an apology, where appropriate and the practice would decide what could be done to prevent a reoccurrence.

The complaints procedure provided the contact details of The Parliamentary and Health Service Ombudsman should a patient remain dissatisfied with the response to their complaint. We saw the complaints procedure displayed in the waiting area.

We looked at a summary of complaints for The Three Shires Medical Practice. It showed there had been five formal complaints recorded across the four surgeries in the last year with no recurring themes. Complaints were considered at significant events meetings and the summary recorded the date the complaint was discussed, the detail of complaint and staff member involved. The summary identified learning points and action to be taken to follow up the complaint.

We saw records showed the practice dealt with complaints in line with its policy. They contained all correspondence relating to the complaint including evidence of how it was responded to and how it had been discussed at meetings.

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 aims and objectives were outlined in the Statement of Purpose. They were concerned with the provision of high quality primary care treatment to patients including consultations, examinations and treatment of medical conditions involving other professionals when it was in the patient's best interests. The practice aimed to involve patients in decisions about their care, for staff to be courteous, approachable and friendly, acting with integrity and maintaining patient confidentiality. It also aimed to ensure that every member of staff and patients were treated fairly and without discrimination and ensure staff were supported, trained and competent in the roles they performed.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The staff handbook listed all of the policies and procedures relating to working with The Three Shires Medical Practice including equal opportunities, disciplinary procedure, holidays and work related stress.

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

The practice also had a range of policies and standard operating procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 11 of these policies and procedures. All 11 policies and procedures we looked at had been reviewed annually and were up to date. There were some areas where the practice could improve its governance arrangements. For example, by considering the use of a more effective infection control audit tool and implementing a system to ensure all care plans are fully competed. In addition, it should implement a formal audit cycle and maintain evidence of the child protection training for all GPs.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the partners was the lead for safeguarding and another for implementation of the Mental Capacity Act 2005.

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.

The managing GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice reviewed data and carried out some clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, following a dossette box dispensing error an audit was conducted in 2013 and again in March 2015. It showed that following a change to practice there had been a significant improvement. However, the GP who conducted the audit was seeking 100% compliance with the practices standard operating procedure and set actions for further improvement.

Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff.

There were monthly meetings for the partners and practice manager. The practice manager set the agenda to discuss business items and monitor the Quality and Outcomes Framework progress.

The practice held whole staff team meetings three times each year where governance issues were discussed. We looked at minutes from the last meeting when there was a review of dispensing errors in 2014/2015 discussed. An audit of errors showed there were very few and an analysis of 'what went wrong'. The minutes showed all staff were present.

Are services well-led?

Good

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

Leadership, openness and transparency

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to staff. One of the staff described the GPs as "wonderful" and said they were the best they had worked for. They told us the GPs never turned staff away if they wanted to speak with them.

We saw from minutes that multi-disciplinary team meetings were held every week. There were meetings to discuss significant events every two months and meetings in each of the surgeries to discuss the dispensing service quality scheme. In addition, there were quarterly medicines management meetings with the South Gloucestershire Clinical Commissioning Group (CCG). The managing partner told us they were planning to introduce clinical meetings for the GPs and nursing staff.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice. They consistently told us they enjoyed working in the practice.

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

The practice encouraged and valued feedback from patients. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

It had gathered feedback from patients through the virtual patient participation group (PPG), surveys and complaints received. The practice was keen to develop the PPG and recognised the logistical problems of having four surgeries within the practice. A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care.

The managing partner showed us the analysis of the last patient survey, which was conducted in May 2015. The results and actions agreed from these surveys were available on the practice website.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training, funded courses as necessary and made time for staff to complete on-line training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, when an administrative error occurred during 2014 all staff were reminded they should use the electronic messaging system to communicate with each other rather than using 'message books'. We saw staff now used this method of communication and administrative errors had reduced.