Coleford Family Doctors

Quality Report

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Date of inspection visit: 23 January 2018
Date of publication: 20/02/2018

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

This practice is rated as Good overall. (Previous inspection September 2016 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Coleford Family Doctors on 23 January 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- The practice held regular meetings to discuss complex cases and safeguarding issues.
- Staff involved and treated patients with compassion, kindness, dignity and respect.

We saw an area of outstanding practice:

- The practice was proactive in identifying patients at risk of diabetes. Patients at increased risk were offered a blood test to measure their average glucose levels every 12 months. They were also offered to attend a group session with one of the practice nurses who led on diabetes, for advice on healthy lifestyle and diet. This meant that the

Summary of findings

practice was not only able to proactively reduce the numbers of patients developing diabetes but offer appropriate management at the outset of the disease for those who were diagnosed with diabetes.

The areas where the provider **should** make improvements are:

- Review and improve systems and processes in relation to the monitoring of the vaccine fridge temperature.
- Review the process for consent forms so they are in line with the most up to date guidelines.
- Identify and implement actions to improve patients' experience.

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

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

Coleford Family Doctors

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector**.** The team included a GP specialist adviser and a practice manager adviser.

Background to Coleford Family Doctors

Coleford Family Doctors are located within Coleford Health Clinic in Coleford, which is a rural market town in the Forest of Dean, Gloucestershire. The practice is situated in a single storey purpose built health centre building and is wheelchair accessible.

Services to patients are provided under a General Medical Services (GMS) contract with NHS England. (A GMS contract is a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract). The practice provides its services to approximately 7,000 patients from the following address:

Coleford Health Centre,

Railway Drive,

Coleford,

Gloucestershire,

GL16 8RH.

Coleford Family Doctors is a dispensing practice. The practice was able to offer dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. The head dispenser is supported by two dispensers who dispense to approximately 1,100 patients which equates to approximately 15% of the practice population.

The practice is located in an area with low social deprivation and is placed in the fourth least deprived decile by public health England. The practice population has a higher proportion of patients aged over 65 compared to local and national averages. For example, 27% of practice patients are aged over 75 compared to the local clinical commissioning group (CCG) average of 20% and the national average of 17%.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice conducted safety risk assessments. It had a suite of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect. We saw minutes of meetings where the practice discussed complex cases to ensure decisions on the care of patients were appropriate, and identify where further improvements could be made.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (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).
- All staff received up-to-date safeguarding and safety training appropriate to their role. GPs and nurses were trained to child safeguarding level three. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control. The practice carried out six monthly infection and prevention control audits and we saw actions were discussed, implemented and monitored.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Referral letters included all of the necessary information.

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing medicines, medical gases, and emergency medicines and equipment minimised risks.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal

requirements and current national guidance. The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.

- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- The practice had signed up to the dispensary service quality scheme which rewards practices for providing high quality care to their dispensing patients. Dispensary staff completed medicine use reviews with patients.
- Medicines were stored securely with access restricted to authorised individuals. The vaccine fridge was locked and stored in the reception area. Fridge temperatures including the minimum and maximum temperature were recorded daily. However, when the fridge's maximum temperature peaked at nine degrees Celsius, which is one degree above the recommended maximum temperature, there was not always a record of the action taken. During our inspection, the practice investigated and found that safety and efficacy of vaccines was assured. The out of range readings were due to the fridge thermometer not being reset appropriately. The practice told us after the inspection that they had purchased a data logger so that there was a second method to monitor the fridge temperatures. This would provide data on the fridge temperature over a period of time when the data is downloaded onto a computer and was in addition to daily manual temperature checks.
- All medicines we checked were within expiry dates. There was a system in place to monitor medicines in stock and their expiry dates and appropriate records were kept.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They were stored securely and access was restricted to appropriate individuals. Suitable arrangements were in place for the destruction of controlled drugs.
- Repeat prescriptions could be ordered by patients online and in person. The dispensary also managed a repeat prescription service for dispensing patients. Requests for high-risk medicines were checked to ensure that the necessary monitoring was in place before being issued and a process was in place to manage requests for medicines which needed to be reviewed by a GP. Repeat prescriptions were signed by a doctor before they were dispensed to patients.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. The standard operating procedures (written instructions about how to safely dispense medicines) had been signed by dispensary staff and were reviewed annually. A bar code scanner was used to check the dispensing process.
- Emergency medicines were easily accessible to staff and were checked regularly to make sure they were in date and safe to use.
- Blank prescription pads and forms were stored securely and there was a system in place to monitor their distribution and use.
- One of the nurses had qualified as an Independent prescriber and could prescribe medicines for clinical conditions within their areas of expertise. Patient Group Directions (PGDs) were in place to allow nurses who were not independent prescribers to administer medicines. (A PGD is a written instruction for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). The health care assistant was trained to administer vaccines against a patient specific prescription or direction (PSDs) from a prescriber. (PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.)

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate

and current picture that led to safety improvements. The practice undertook an annual review of significant events where actions taken to prevent the same things happening again were reviewed.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, following an incident where a referral was not acted upon in a timely manner, the practice changed its process so that all urgent referrals were passed to the duty doctor to be processed immediately.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups except for patients with long term conditions where the practice was rated as outstanding.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The average daily quantity of Hypnotics prescribed per Specific Therapeutic group (07/2016 to 06/2017) was 0.91 which was comparable to the clinical commissioning group (CCG) of 1.03 and national average of 0.90.
- The number of antibacterial prescription items prescribed per Specific Therapeutic group Age-sex Related Prescribing Unit (STAR PU) (07/2015 to 06/2016) was 1.00 which was comparable to the CCG average of 0.96 and national average of 0.98.
- Percentage of antibiotic items prescribed that were Cephalosporins or Quinolones (01/07/2015 to 30/06/2016) was 7.8% which was comparable to the CCG average of 4.4% and national average of 4.7%.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used their computer systems to undertake searches of patients to undertake clinical audits and monitor performance against the Quality Outcomes Framework (QOF) to improve outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice.).
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

This population group was rated as good.

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. Those identified as being frail had a clinical review including a review of medication.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- The practice held monthly primary health care meetings with community based staff where care plans were routinely reviewed and updated.
- Patients who were housebound were visited by the nursing team for flu immunisation, and chronic disease management.

People with long-term conditions:

This population group was rated as outstanding.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Patients with long-term conditions had a structured annual review to check their health and medicine needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff responsible for reviews of patients with long term conditions had received specific training. For example, a nurse had undertaken the University of Warwick training in diabetes.
- The practice was proactive in identifying patients at risk of developing diabetes. These patients were offered the opportunity to attend a "Pre diabetic group" session with one of the nurses with specialist knowledge of diabetes. Information from the practice showed that 95 patients had attended a session at this group, since it started in October 2016. The practice undertook an audit of a sample of patients who had attended this group which showed that, out of 11 patients who had a follow up blood test, five patients had reduced blood glucose levels, four patients maintained the same levels, one patient's blood glucose levels had increased and one patient was diagnosed with diabetes. This meant

Good

Are services effective?

(for example, treatment is effective)

that the practice was not only able to proactively reduce the numbers of patients developing diabetes but offer appropriate management at the outset of the disease for those who were diagnosed with diabetes

- The percentage of patients on the diabetes register with a record of a foot examination and risk classification was 97% compared to the clinical commissioning group (CCG) average of 92% and the national average of 90%.
- The percentage of patients with diabetes, on the register, in whom their last blood test was within the target range was 85% compared to the CCG average of 82% and national average of 80%.
- The percentage of patients with chronic obstructive pulmonary disorder (a chronic lung disease) who have had a review in the last 12 months (2016/17) was 92% compared to the CCG average of 93% and national average of 90%.

Families, children and young people:

This population group was rated as good.

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given ranged between 94% and 96% which were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines.
- We saw positive examples of joint working with midwives, health visitors, mental health workers, community nurses and social prescribers through minutes of monthly multidisciplinary safeguarding meetings.

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

This population group was rated as good.

- The practice's uptake for women aged 25-64 whose notes record that a cervical screening test has been performed in the preceding five years was 81% which was comparable to both the clinical commissioning group average of 83% and the national average of 81%.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

This population group was rated as good.

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice had 83 patients with learning disabilities registered and 63 of those patients (76%) had received an annual health check to date. Patients were also offered six monthly reviews. There was a lead GP for patients with severe learning disabilities and a lead nurse for those with less severe learning disabilities.

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

This population group was rated as good.

- 76% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the clinical commissioning group (CCG) of 87% and national average of 84% .
- 95% of patients with severe mental health problems had a comprehensive care plan documented in their record in the last year (2016/17) which was comparable to the CCG average of 94% and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 92%; CCG 93%; national 91%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. The practice undertook regular clinical audits to monitor the quality of care at the practice. We reviewed one

Good

Are services effective?

(for example, treatment is effective)

complete cycle clinical audit where actions had been implemented and improvements monitored. For example, the practice undertook an audit of patients taking a medicine for bladder problems. The first audit showed that three out of eight patients had not had their blood pressure checked since starting treatment. The practice discussed the findings at their clinical meetings and all clinical staff were made aware of updated guidelines when prescribing this medicine. A re-audit in 12 months identified that all patients who had been prescribed this medicine had their blood pressure checked at the start of their treatment and within a reasonable timescale after the commencement of treatment.

The most recent published QOF results showed the practice had achieved 100% of the total number of points available compared with the clinical commissioning group (CCG) average of 98% and national average of 96%. The overall exception reporting rate at the practice was 9% compared with the CCG average of 12% and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- The percentage of patients with diabetes, on the register, whose last measured total cholesterol (2016/17) was within the target range or less was 87% compared to the clinical commissioning group (CCG) average of 81% and the national average of 80%.
- The percentage of patients with diabetes, on the register, who have had influenza immunisation in the preceding 1 August to 31 March was 99% compared to the CCG average of 97% and national average of 95%.
- The percentage of patients with asthma, on the register, who have had an asthma review in the preceding 12 months (2016/17) that includes an assessment of asthma control using the three Royal College Physician questions was 81% compared to the CCG average of 77% and national average of 76%.
- Where appropriate, clinicians took part in local and national improvement initiatives. For example, the practice had worked with the CCG and other neighbouring practices to implement improvement initiatives such as improving patient access to a GP.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring and support for revalidation. The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing. Arrangements were in place for GPs to receive peer support and audit of consultations.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

Good

Are services effective?

(for example, treatment is effective)

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers. The practice was proactive in identifying patients at risk of developing diabetes.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately. However, we noted that consent forms for minor surgery and intrauterine contraceptive devices were not in line with the most up to date guidelines. For example, it did not detail the risks and benefits of the procedure and alternative treatment available although we were told that these were discussed with patients. The practice took immediate action during the inspection and amended their consent forms to ensure they were in line with current guidelines.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Three of the four patient Care Quality Commission comment cards we received were positive about the service experienced. One of the comment cards referred to prescription issues. The NHS Friends and Family Test for October 2017 showed that 86% of patients would recommend this practice to their friends and family.

Results from the annual national GP patient survey, published in July 2017 showed patients felt they were treated with compassion, dignity and respect. Two hundred and twenty-one surveys were sent out and 115 (52%) were returned. This represented about 2% of the practice population. The practice was below average for its satisfaction scores on consultations with GPs and nurses. For example:

- 87% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 82% of patients who responded said the GP gave them enough time; CCG - 89%; national average - 86%.
- 100% of patients who responded said they had confidence and trust in the last GP they saw; CCG - 98%; national average - 95%.
- 82% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG– 90%; national average - 86%.
- 84% of patients who responded said the nurse was good at listening to them; (CCG) - 93%; national average - 91%.
- 89% of patients who responded said the nurse gave them enough time; CCG - 94%; national average - 92%.
- 96% of patients who responded said they had confidence and trust in the last nurse they saw; CCG - 98%; national average - 97%.
- 85% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG - 93%; national average - 91%.
- 91% of patients who responded said they found the receptionists at the practice helpful; CCG - 90%; national average - 87%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given):

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas, including in languages other than English, informing patients this service was available.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. The practice used opportunities, such as during registration and flu clinics to ask patients specifically if they had caring responsibilities. They had also specifically asked patients if they were carers when undertaking annual surveys. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 258 patients as carers (approximately 4% of the practice list).

Good

Are services caring?

- A member of staff acted as a carers' lead to help ensure that the various services supporting carers were coordinated and effective. There was a dedicated carer's information folder in the waiting area.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was followed by a consultation at a flexible time and location to meet the family's needs.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. However, results were below local and national averages in some areas:

- 79% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 90% and the national average of 86%.
- 75% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.
- 91% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92%; national average - 90%.
- 78% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88%; national average - 85%.

The patient participation group (PPG) told us that the practice worked closely with the group and discussed survey results with them. At the time of the inspection, the PPG and the practice were discussing this year's annual survey and suitable questions were being drafted to identify areas of improvement.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services across all population groups.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example extended access to see a GP, online services such as repeat prescription requests, advanced booking of appointments, advice services for common ailments.
- The practice had recently developed and implemented an access hub with 10 other practices in the area in order to improve patient access to primary care services. Additional GP and Nurse Clinics were held during normal hours and additional appointments were also offered at one of the participating surgeries between 6.30 pm and 8.00 pm on weekdays and on Saturday mornings. Patients registered with any GP practice within the Forest of Dean were able to book an appointment at these extra clinics. We saw evidence that the practice manager had been instrumental in the successful roll out of this project.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, nurses visited house bound patients to undertake reviews of their long-term health conditions.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and practice nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- The practice worked closely with the community nursing team who were situated in the same building particularly for the monitoring of patients on the end of life care.
- The practice supported two local nursing homes and a dedicated GP visited the homes regularly and ensured that quarterly care plan reviews were carried out.
- The practice held monthly primary health care meetings with community based staff where care plans were routinely reviewed and updated.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients identified at risk of developing diabetes were offered annual blood test and the opportunity to attend a group session with one of the practice nurse who led on diabetes, where they received advice and support on healthy lifestyle and diet.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- Parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- We saw positive examples of joint working with midwives, health visitors, mental health workers, community nurses and social prescribers through minutes of monthly multidisciplinary safeguarding meetings.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The practice had implemented a 24 hour telephone service which allowed patients to book or cancel appointments via an automated telephone system.
- Additional appointments were available until 8pm on a rotational basis with other local practices.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice displayed information for carers in the waiting room, on their website, on the waiting room information screen and offered carers health checks.
- The practice held a register of carers and supported them to receive appropriate support.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- One of the GPs had received additional training and had a special interest in mental health and was able to provide additional support to patients experiencing poor mental health.

Timely access to the service

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was mixed. This was supported by observations on the day of inspection and completed comment cards. Two hundred and twenty-one surveys were sent out and 115 (52%) were returned. This represented about 2% of the practice population.

- 71% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 76%.
- 67% of patients who responded said they could get through easily to the practice by phone; CCG – 81%; national average - 71%.
- 82% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG - 89%; national average - 84%.
- 80% of patients who responded said their last appointment was convenient; CCG - 87%; national average - 81%.
- 66% of patients who responded described their experience of making an appointment as good; CCG - 80%; national average - 73%.
- 36% of patients who responded said they don't normally have to wait too long to be seen; CCG - 62%; national average - 58%.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Nine complaints were received in the last year. We reviewed three complaints in detail and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, when a complaint was made about the attitude of reception staff, the practice arranged for staff to receive additional training in customer care.

Are services well-led?

Good

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. They recognised the importance of continuity of the service and had succession planning as a business priority.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population. The practice had worked closely with other local practices to deliver a local project to improve patient access to GPs. The practice manager organised the cross-practice rota for this service to be delivered.
- The practice monitored progress against delivery of the strategy.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. For example, one of the patients we spoke with told us that when they made previously made a complaint, the practice investigated this and apologised to the patient. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included appraisal and career development conversations. All staff had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out,

Are services well-led?

Good

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

understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.

- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of MHRA alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made, this was with input from clinicians and the patient participation group (PPG) to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, the practice worked closely with the PPG to undertake surveys and drive improvement in the practice.
- Staff also told us that they were able to suggest improvement ideas and that this was implemented by the practice. For example, one of the nurses suggested running group for patients at risk of developing diabetes. The practice facilitated this to take place.
- There was an active PPG and they were positive about the engagement between the practice and the group.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

Are services well-led?

Good

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

- There was a focus on continuous learning and improvement at all levels within the practice. For example, the practice had plans for one of the recently recruited nurses to complete specific training in diabetes.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.