Hilary Cottage Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Hilary Cottage Surgery is a semi-rural GP dispensing practice providing primary care services to patients resident in Fairford and the surrounding villages Monday to Friday. The practice has a patient population of approximately 7,200 patients of which 24% are over 65 years of age.

We undertook a scheduled, announced inspection on 11 November 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor.

Our key findings were as follows:

The overall rating for Hilary Cottage Surgery was good. Our key findings were as follows:

- Staff were caring and treated patients with kindness and respect.
- The practice worked with other health care providers to enable prompt treatment, reduce hospital admissions and enabled patients to be treated at home.
- Patients who had a 'same day' need were able to speak to or see a GP on the day they contacted the practice.
- Patients were cared for in an environment which was clean and reflected nationally recognised infection control practices.
- Patients were protected from the risks of unsafe medicine management procedures.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- GPs and nursing staff followed national clinical guidance.
- The practice had systems to identify, monitor and evaluate risks to patients.
- Patients were treated by suitably qualified staff.

We saw some outstanding practice:

- The practice had a system in place to assess the quality of the dispensing process and had signed up to

Summary of findings

the Dispensing Services Quality Scheme (which includes DRUMS – a dispensers' review of the use of medicines). The practice had completed the criteria for successful achievement.

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

The provider should:

- Improve the completion of significant event records. Ensure all staff are enabled to attend meetings to discuss concerns, ideas and learning from events which affect their practice

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. The practice used a range of information to identify risks and improve quality regarding patient safety. There were systems for reporting, recording and monitoring significant events. There were processes which recognised and supported patients who were at risk of abuse. Staff were aware of their roles and responsibilities with regard to protecting patients from abuse or the risk of abuse. There was written guidance for the recruitment and selection of new staff. The practice had a system to enable sufficient staff numbers to meet service requirements.

Patients were cared for in a safe environment. The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies. Equipment was regularly serviced and maintained.

Patients were protected from the risks of unsafe medicine management procedures. Medicines were stored, checked and records accurately maintained in line with legal and safety requirements.

Patients were cared for in an environment which was clean and reflected appropriate infection control practices.

Are services effective?

Good

The practice is rated as good for providing effective services. Patients' care and treatment was delivered in line with recognised best practice standards and guidelines. The practice met nationally recognised quality standards for improving patient care and maintaining quality and compared favourably with other practices in the area. The practice had a system in place for completing clinical audit cycles to evidence treatment was in line with recognised standards.

Patient care was improved by the regular monitoring of treatment. The practice worked with other health care providers to enable prompt treatment, reduce hospital admissions and enable patients to be treated at home.

Patients' rights were protected with regard to the consent process. Staff were confident in their understanding of their legal and ethical responsibilities for gaining informed consent prior to treatment.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services. Patients were generally positive about their care and treatment. We observed staff were supportive in their interactions with their patients and had the skills to support patients. Patient privacy and confidentiality was not easily maintained in the practice reception and waiting area. The practice was aware of the importance of maintaining confidentiality and privacy and, had an action plan to address the issues. Patients were involved in treatment choices.Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Patients told us that information to help them understand the services available was easy to understand.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice delivered core services to meet the needs of the main patient population it treated.

Overall the practice enabled patients to access the care they needed. Patients were able to speak or see a GP if they required an urgent appointment. However, some patients told us they were concerned there was a wait of three to four weeks to see the GP of choice and appointments often ran late.

The practice had arrangements in place to support patients with disabilities. There was a loop system for patients with hearing difficulties. The layout of the building enabled patients with mobility needs to gain access without assistance.

The practice had a comprehensive complaints system. The practice responded to patients' concerns and suggestions to improve the primary care services provided.

Are services well-led?

Good

The practice is rated as good for being well-led. Patients were cared for by staff who were aware of their roles and responsibilities for managing risk and improving quality. There were clear governance structures and processes in place to keep staff informed and engaged in practice matters.

Staff told us they worked well as a team and were supported to undertake their role. GPs and nurses were encouraged to update and develop their clinical knowledge and skills. Each member of staff had a comprehensive annual performance review and personal development plan.

Summary of findings

Patients' views about the service were listened to and were used to improve services. The practice had a Patient Participation Group (PPG) to promote and support patient views and participation in the development of services provided by the practice. There was a system in place to review and respond to complaints.

Patients were protected from risk. The practice measured, collected and monitored data to meet nationally recognised standards for improving patient care and maintaining quality. There was a system for reporting, recording and monitoring significant events which the practice used to make changes. For example, changes to medicines and prescription dispensing practice to prevent risks to patients.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. The practice supported older patients by enabling access to services without patients having to attend the practice. The practice was responsive to the needs of older patients, including offering home visits and rapid access appointments for those with enhanced needs. Housebound patients could request telecare (a system to remotely convey information about a patient's health). Nationally reported data showed the practice had positive outcomes for conditions commonly found amongst 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. The practice worked with other health care providers to enable prompt treatment, reduce hospital admissions and enable patients to be treated at home.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Emergency processes were in place and referrals made for patients who had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check 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. The practice had in place advance care planning to support patients with long term conditions to achieve their end of life choices and decisions.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.Systems were in place for identifying and following-up children who were at risk. For example, the GP met regularly with health visitors to review children and their families at risk. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. GPs offered a range of contraceptive services for patients.

Summary of findings

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 practice supported the working age population and those recently retired by providing screening for common medical conditions. They offered a flexible appointment system and access to information and services via the practice website.

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 with learning disabilities. The practice carried out annual health checks for patients with learning disabilities. Longer appointments for patients with learning disabilities were provided by the practice in recognition of the time needed to involve patients in their care and treatment.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and who to contact within the practice.

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 with dementia). The practice had started care plans for patients experiencing poor mental health. Quality data Quality and Outcomes Framework Data 2013/2014 (QOF is a national performance measurement tool) demonstrated the practice compared favourably with other practices in the assessment of depression. The practice regularly monitored patients for the side effects of certain medicines used in the treatment of mental health conditions.

We saw the practice website included links to other information and support services. A monthly clinic was held in the surgery by a visiting Psychiatrist

The practice carried out annual health checks for patients with dementia.

Summary of findings

What people who use the service say

On the day of the inspection we spoke with seven patients attending the practice. We looked at 17 patient comment cards, feedback from the practice's patient surveys (2013 and 2014), and the GP National Patient Survey 2013/2014. We also spoke to a representative from the practice's Patient Participation Group.

Overall, patients we spoke with were satisfied with the care and treatment received. They described staff as efficient, friendly and understanding. This was supported by feedback from the GP National Patient Survey 2014 which indicated 87% of the practice respondents said the last GP they saw treated them with care and concern. 76% of respondents described their experience of the practice as 'fairly good' or 'very good'. Patients felt their privacy and dignity were respected by staff although two patients said maintaining privacy in the reception area was difficult. The reasons given for this were the size of the area and its close proximity to the dispensary. This was confirmed by the GP National Patient Survey which demonstrated 59% of respondents were satisfied with the level of privacy in the reception area.

All of the patient feedback told us patients were able to get to see or speak to a GP if their appointment was urgent. However, patients we spoke with said there was often a wait of up to three to four weeks to see the GP of their choice. All of the patients told us their appointment time often ran late although it was acknowledged this was because the GPs did not rush patients and were thorough. This was confirmed by the GP National Patient Survey 2013/14 where 40% of patients said they waited more than15 minutes for their appointment. Patients we spoke with were not aware of the complaints process. However, they expressed confidence in the practice to address concerns when they were raised.

Patients' feedback told us patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. This was supported by feedback from the GP National Patient Survey 2013/14 which indicated 82% of patients said their GP was 'good at explaining tests and treatment'.

Patients were satisfied with the service provided by the practice dispensary. The practice patient survey (2013) demonstrated 96% of respondents found it fairly or very easy to get their repeat prescriptions.

Patients told us they were satisfied with the cleanliness of the practice and this was confirmed by the practice patient survey.

Outstanding practice

- The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme (which includes DRUMS – a dispensers' review of the use of medicines). The practice had completed the criteria for successful achievement.

Hilary Cottage Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Hilary Cottage Surgery

Hilary Cottage is a small semi-rural dispensing practice providing primary care services to patients resident in Fairford, Gloucestershire and surrounding villages. The practice is purpose built with most patient services located on the ground floor of the building. The practice has a patient population of approximately 7,200 patients of which 24% are over 65 years of age.

The practice has three male and one female GP partners. The male GP partners work full time and the female GP partner half time. They employ three salaried GPs who work part time, four nurses, a healthcare support worker, phlebotomist, a practice manager, deputy practice manager and ten reception/administration staff . The dispensary is staffed by a dispensing manager and five part time dispensers.

Each GP has a lead specialist role for the practice and nursing staff have specialist interests such as respiratory disease and diabetes.

Primary care services are provided by the practice Monday to Friday during working hours (8.30am-6.30pm). In addition late evening appointments are available two days a week up to 8pm. GPs are available for telephone advice and home visits. The practice has opted out of the Out of Hours primary care provision. This is provided by another Out of Hours provider.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to 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

Detailed findings

- 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)

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

We carried out an announced inspection on the 11 November 2014. During the inspection we spoke with five GPs, the practice manager, three nursing staff, administration and dispensing staff. We spoke with seven patients who used the service. We looked at patient surveys and comment cards. We observed how staff talked with patients.

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

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as 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, the use of DATIX (incident reporting system) to report hospital errors. Staff also gave examples of how they reported patient safeguarding concerns and other incidents.

We saw from incident reviews how dispensing staff were vigilant and had identified a number of prescribing errors made by other healthcare providers. These were addressed in a timely manner.

There were records of significant events that had occurred during the last 18 months and we were able to review these.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we were able to review these. Significant events were reviewed at the practice's monthly team leaders meeting and at a dedicated quarterly significant events meeting. All staff were invited to participate although attendance was not compulsory. We noted not all records of the reviews were consistently completed. We saw there was a brief documentation of actions taken and learning for future improvement. The document did not provide staff who had not attended the meetings with sufficient information about changes in practice and procedures. Minutes of significant events were disseminated to all staff in hard copy with a covering sheet for signature

Four staff members had responsibility for safety alerts and the practice manager kept a file of all alerts received. Information was disseminated to respective members of staff for their specific attention. For example where a Medicines and Healthcare Products Agency (MHRA) alert was received regarding the prescribing of a medicine used for the treatment of osteoporosis. The relevant GPs were informed and their actions resulted in a change of medicines prescribed. We were shown an MHRA alert received on the day of the inspection regarding the prescribing of a specific antibiotic for patients with impaired kidney function. Audit records demonstrated patients' medicines records were reviewed and patients were informed of changes made to prescribing based on the information received. Staff knew how to access the safety alert information.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. There were training records from the last three years and we were able to review these. All nurses and GPs had been trained to level three safeguarding children in line with national guidance. All GPs had completed safeguarding vulnerable adults training. Most administrative staff had completed safeguarding children and vulnerable adults. All the staff we asked were able 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 in working hours and out of normal hours.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and a GP for safeguarding children. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's patient record system. This included information to make staff aware of any relevant issues when patients attended appointments, for example children with child protection plans. The examples staff gave us to demonstrate how they had managed safeguarding concerns were in line with the practice policy. We saw records demonstrated the GPs acted promptly to report safeguarding concerns to relevant partner agencies. This included information received from accident and emergency departments regarding children's injuries. Staff told us if they had specific concerns about a child who had not attended for immunisations they would report this to the health visitor and contact the parent. The GPs and health visitors told us they met regularly together with

other members of the multidisciplinary team every two months to discuss at risk children and their families. In addition the GPs told us they met with other practices in the area every four months to discuss complex cases.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. All staff required to act as a chaperone had undertaken training and understood their responsibilities in the role.

There was a system for reviewing repeat medications for patients with co-morbidities/multiple medications. We were told changes to patients' medicines by other healthcare providers were addressed by the GPs or the practice nurse and the healthcare provider was contacted if a discharge summary had not been received. There was an alert on the patient record system to ensure patients received an annual medicines check. The practice also participated in a dispensing practice quality assurance scheme which required a number of patients to have their medicines reviewed to ensure they were prescribed the appropriate medicines.

Medicines management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a protocol which ensured medicines were kept at the required temperatures, and the action to be taken in the event of temperatures not being maintained. Records we saw showed there had been a recent medicines refrigerator failure. We saw the actions taken protected patients from risks related to unsafe medicines.

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 nurses and the health care assistant administered vaccines using directives produced in line with legal requirements and national guidance. We saw the authorisations of staff to use the patient group directive (a patient group directive is written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment) were completed. The nurses and healthcare support worker had received the appropriate training to administer vaccines.

Repeat prescriptions were issued in line with the practice protocol. Repeat prescriptions were reviewed regularly and some patients were recalled for ongoing monitoring. Patients requesting medicines not on repeat prescription were not able to order on-line. There was a system in place for the management of high risk medicines such as blood thinning agents, which included regular monitoring in line with national guidance. Appropriate action such as informing patients of the test results and adjusting medicines doses was taken based on the results.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme (DRUMS – a dispensers' review of the use of medicines. The scheme rewards practices for providing high quality services to patients of their dispensary). We saw evidence the GPs and nurses undertook patient reviews of medicines as part of the quality assurance process to ensure patients were prescribed appropriate medicines.

Records showed all members of staff involved in the dispensing process had received appropriate training and their competence was checked regularly by the dispensing manager supported by the GP lead for medicines management.

The practice had established a service to deliver medicines to housebound patients.

Cleanliness and infection control

We observed the premises were visibly clean and tidy. There were cleaning schedules in place and cleaning

records were kept. Patients we spoke with told us they found the practice clean and had no concerns about cleanliness or infection control. This was confirmed by results from the practice patient survey (2013) which indicated 95% of respondents thought the practice was fairly or very clean.

The practice had a member of staff with a lead responsibility for infection control who had undertaken further training. This enabled them to provide advice about the practices infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received updates every one to two years. We saw evidence the infection control lead had completed an infection control audit in 2014. Most areas of improvement identified in the audit had been completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available to and used by staff. There was also a policy for needle stick injury and processes in place to prevent staff contracting infections from this type of injury.

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. We noted hand washing sinks in clinical areas had plugs which was not in line with national guidance. The taps in the hand washing sink in the minor operations room were not long handled as recommended in clinical settings.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records confirmed the practice had a legionella assessment and was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw records demonstrating equipment was tested and maintained regularly. 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, blood coagulation testing equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with professional bodies and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 enough staff were on duty. There were arrangements 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 although at times it was very busy. The practice manager showed us records to demonstrate actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Members of staff knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed staff had discussed a medical

Good

Are services safe?

emergency concerning a patient and the practice had learned from this. This related to a patient who had an anaphylactic (extreme allergic reaction) reaction and collapsed. Learning from the event resulted in a form being developed to record the patient's basic signs and responses as guidance for emergency services when they arrived.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. There were relevant contact details available for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. We saw the practice had responded in line with their policy when there was a power cut to the medicines refrigerators and the integrity of vaccines was compromised.

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

Risks associated with service and staffing changes (both planned and unplanned) were accounted for.

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). The GPs and nurses we spoke with gave examples of how they applied national guidance to their practice for example, the use of specific wound dressings for leg ulcers. We found from our discussions with the GPs and nurses completed assessments of patients' needs in line with NICE guidelines, such as the management of patients with diabetes. These were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Nursing staff we spoke with told us they approached the GPs for advice when they had concerns about a patient's condition such as elevated blood pressure or blood glucose levels.

Quality and Outcomes Framework Data 2013/2014 (QOF is a national performance measurement tool) demonstrated the practice compared favourably with regional and national results regarding the monitoring and review of patients with a range of chronic conditions including high blood pressure, diabetes and respiratory disease. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. GPs met every two weeks with community nurses and formally every three months with the multidisciplinary team to review the most vulnerable patients. These meetings discussed patients with chronic long term conditions and those at risk of unplanned hospital admissions. In addition patients with palliative care needs and their families were reviewed every three months or as required.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients for example, with suspected cancer. We saw records which demonstrated peer reviews of hospital referrals. GPs told us they used audit data to demonstrate how the reviews had impacted on their practice. For example, a reduction of referrals and an increase in the use of national guidance to make decisions.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with all staff we spoke with showed the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was used to support the practice to carry out clinical audits.

The practice showed us two examples of complete clinical audit cycles. One audit demonstrated an improvement in recording patient consent to the insertion of a contraceptive implant. The other showed there were no complications following joint injections. We were told audits took place to evaluate the system to manage the follow-up of patient test results following minor surgery.

The GPs told us clinical audits were often linked to medicines management information for example, safety alerts or as a result of information from the QOF. We saw an audit regarding the prescribing of medicines used for osteoporosis. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, we were told an average of 99.97% of patients with diabetes had an annual medication review. QOF data 2013/2014 demonstrated the practice compared favourably with regional and national results regarding the monitoring and review of patients with a range of chronic conditions including high blood pressure, cancer and respiratory disease. The average practice QOF result for all conditions monitored was 98% to100%. The practice was not an outlier for any QOF (or other national) clinical targets.

Good

Are services effective?

(for example, treatment is effective)

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked 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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. Patients taking a number of repeat medicines were reviewed by the GP or nurse as part of the dispensers' review of medicines.

The practice had achieved and implemented the Gold Standards Framework for end of life care. It had a palliative care register and had regular informal meetings with community staff as well as multidisciplinary meetings every three months to discuss the care and support needs of patients with palliative needs and their families.

The practice also participated in local benchmarking run by the clinical commissioning group (CCG). Benchmarking is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmark data showed the practice compared favourably to other practices in the area with regard to the support of patients with palliative care needs and diabetic screening.

Effective staffing

We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life support.

GPs were up to date with their yearly continuing professional development requirements and all either had 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council). Registered nurses were in date with their professional registration requirements.

All staff had annual appraisals which identified learning needs from which action plans were documented. Interviews with staff confirmed the practice were supportive of staff members' training needs. There was a training policy as guidance for staff. The practice was a registered training practice. Trainee GPs were provided with extended patient appointments to support patient diagnosis and treatment plans. The trainee GPs had access to a senior GP throughout the day for support and clarification of complex decisions.

Practice nurses were trained to fulfil defined duties for example, administration of vaccines, cervical cytology and monitoring blood clotting times for patients on blood thinning medicines. Those with extended roles for example, insulin initiation for diabetics and asthma management had relevant qualifications such as diplomas in asthma and diabetes as well as access to specific courses for insulin initiation.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries both electronically and by post. Reports from the out-of-hours GP services were received in the same way. 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. We saw from the significant event reviews there had been two examples where practice dispensing staff had identified errors in patients' medicines on discharge from hospital. Staff took prompt actions to reduce the risk to patients.

The practice met regularly with community staff who were based at the practice. The practice had negotiated with another healthcare provider to provide onsite accommodation for community nurses and health visitors. Community staff and GPs told us this assisted communication which worked well. We were given an example of a potential safeguarding issue to demonstrate how the arrangement had improved support.

The practice held multidisciplinary team meetings every three months to discuss the needs of complex patients, or long term conditions for example, those at risk of emergency admission to hospital or children on child protection plans. These meetings were attended by district nurses, health visitors and palliative care nurses.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider

Good

Are services effective?

(for example, treatment is effective)

which enabled patient data to be shared in a secure and timely manner. There was a dedicated telephone number for access to the practice duty GP and for outside agencies for example, the emergency department and paramedics.

Electronic systems were also in place for making referrals to consultants, and the practice made a range of referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

GPS were able to access computer based patient records held by the community nurses and health visitors with patient consent.

For emergency patients, there was a form developed by the practice to record patients' vital signs and emergency treatments given. This accompanied the patient with a copy of the patient's summary record to A&E.

The practice was signed up to the electronic Summary Care Records system. (Summary Care Records is a national initiative to provide key clinical information to healthcare staff treating patients in an emergency or out of normal hours). The records were accessible to other healthcare providers and patients via secure online access. Comprehensive patient information regarding the system was in the practice leaflet and on the practice website.

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. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

Staff were aware of the Mental Capacity Act (MCA) 2005 and their duties in fulfilling it. All GPs had completed Mental Capacity Act Training and four GPs had undertaken additional training at the time of inspection. The practice had developed a template to be used on the patient electronic record. The template included information regarding the MCA and prompts to consider when assessing whether a patient had mental capacity to consent to treatment. Nurses explained that for patients with impaired capacity they would take extra time to explain treatment; ask patients to explain what they understood about their treatment and involved carers with the patient's permission. When nurses were not sure the patient understood or had given informed consent they told us they sometimes suggested making another appointment. Nurses referred patients back to a GP when they refused treatment which nurses considered to be in the patient's best interest. Staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

GPs told us patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal and written consent was to be documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown a re-audit (October 2014) that confirmed the written consent process for joint injections for minor surgery had improved with 100% patients having written consent.

Health promotion and prevention

It was practice policy to offer all new patients who registered with the practice a health check with the health care assistant / practice nurse. The GP was informed of all health concerns detected and these were followed-up. If the patient was taking prescribed medicines then they would be seen by the GP.

Nursing staff used their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, offering smoking cessation advice to smokers and weight management programmes. There was a comprehensive range of health promotion information in the practice and links on the practice website which included mental health and sexual health advice.

The practice offered NHS Health Checks to all its patients aged 40-75.

The practice had ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of

Good

Are services effective?

(for example, treatment is effective)

all patients with learning disabilities and dementia. These patients were offered an annual physical health check. There was a robust recall system for patients who did not attend.

The practice's performance for cervical smear uptake was 78.6% which was above the Gloucestershire Clinical Commissioning Group (CCG) average. The practice performance for national mammography (in last three years prior to 2013) was above Gloucestershire CCG (78.6% and 77.1% respectively). The uptake for national bowel screening (over six months 2013) was not significantly different from Gloucestershire CCG (64.5% and 63.9% respectively).

The practice offered a full range of immunisations for children, older adults and travel vaccines. Flu vaccinations were in line with current national guidance. Patients identified as carers were offered flu vaccinations. Patients over the age of 75 years were also able to have a shingles injection. Overall last year's performance for all immunisations was above average for the CCG. There was a protocol for following up patients who did not attend clinics or appointments related to health promotion or prevention.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey and a survey of 177 patients undertaken by the practice (2013). The evidence from all these sources showed 75% described their experience of the practice as 'good', 'very good' or 'excellent'. This was confirmed by data from the GP National Patient Survey 2013/2014 which showed 79% of respondents described their overall experience as 'good' with 72% of respondents who would recommend the practice and 87% of patients in the GP Patient Survey said the last GP they saw was 'good' at treating them with care and concern'.

The GP National Patient survey demonstrated overall the practice scored lower than the clinical commissioning group (CCG) average for most questions. The practice were aware of the scores and were working towards resolving the outstanding issue of patient privacy in the reception and waiting area.

Patients completed CQC comment cards to provide us with feedback about the practice. We received 17 completed cards and all were positive about the service experienced. Patients said they felt the practice offered a 'good' service including the dispensary. The staff were described as friendly, professional and caring. Three patients gave specific examples of the care and management provided by the GPs. The comments said staff treated them with dignity and respect. Six of the seven patients we spoke with on the day of our inspection told us they were satisfied with the care provided by the practice and said their dignity was respected. One patient was not satisfied with the appointment system at the practice because of the wait to get an appointment with a GP of their choice.

Staff and patients told us 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 patients' privacy and dignity was maintained during examinations, investigations and treatments. We saw consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard. However, we observed the reception area and dispensary hatch were in close proximity which caused congestion particularly in the morning and could lead to patients overhearing private conversations. This was commented on by patients and was reflected in the GP Patient Survey (2013/14) where 38% patients said they could be overheard and were not happy with it. The practice had started to address the concern. For example, there was a patient self-check in system and telephones were sited in a room behind the reception desk so conversations could not be overheard. The practice manager told us they were trying a 'white noise' machine so conversations in reception could be less easily overheard in the waiting room.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients' responses to questions about their involvement in planning and making decisions about their care and treatment was less than the clinical commissioning group average. However, this was not confirmed by the patient comment cards or the patients we spoke with on the day. All but one patient told us their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive

Nursing staff described examples of how patient choice was respected. For example, changing patient appointment times to meet lifestyle commitments. Patients were involved in their treatment. For example, patients with diabetes using insulin to manager their blood sugar and keeping their own diary of blood results and other test results to monitor their progress.

The GPs told us they supported patients and their carers to consider their end of life care choices. For example, decisions about do not attempt cardio pulmonary resuscitation. The process described by GPs gave patients time to consider their decisions after having been provided with information.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 87% of

Good

Are services caring?

respondents to the GP National Patient Survey (2013/2014) said the last GP they saw treated them with care and concern. 94% said they had confidence and trust in the last GP they saw. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff were careful and willing listeners, kind and caring.

Information in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

Staff told us if families had suffered a bereavement their usual GP contacted them and a visit was arranged.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Overall we found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided.

There had been very little turnover of staff during the last three years which enabled continuity of care and accessibility to appointments with a GP of choice. This included appointments with a named GP or nurse.

Home visits were made to a local care home by a named GP and to those patients who needed one. Patients who were unable to attend the practice due to ill health or work commitments could request a telephone consultation. In addition housebound patients could request telecare (a system to remotely convey information about a patient's health). Patients who were too unwell to attend the practice could request a home visit.

The practice's website provided a facility for patients to order a repeat prescription and book an appointment with a GP. The practice dispensary arranged a medicines delivery service to outlying villages.

The practice was open late two evenings per week for pre-booked appointments to accommodate patients not able to attend the practice during routine practice hours. In addition there was a late evening clinic on alternate Wednesdays until 8pm, for health promotion including asthma management.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, collecting and updating patient contact details for text messaging of appointment reminders.

The practice had implemented the Gold Standards Framework for end of life care. They had a palliative care register and held quarterly multidisciplinary meetings in addition to community nurses meetings every two weeks to discuss patients' and their families' care and support needs.

The practice delivered an enhanced service (locally developed service over and above the essential/additional services normally provided to patients) to co-ordinate and manage the care of frail older patients to avoid unplanned admissions to hospital. The practice used a recognised assessment tool to identify patients at risk. The practice held regular meetings with other health care providers and developed patient care plans to enable the most appropriate support for patients.

Patients prescribed with blood thinning medicines had their blood test to determine blood clotting time. The practice undertook minor operations and joint injections for patients who had been assessed as suitable for the treatment. These reduced the need for patients to travel to the hospital for the same investigation.

The practice offered a range of contraceptive services including contraceptive coil and implant insertion.

The practice manager told us they had use of a four by four vehicle in poor weather conditions to bring patients to the practice and deliver prescriptions.

Tackling inequity and promoting equality

The practice premises were purpose built with most patient services on the ground floor. The building enabled patients with mobility needs to gain access without assistance. A section of the reception desk was lower for wheelchair users although these adjustments had not been made to the dispensary hatch. The practice had an induction loop system for patients with hearing difficulties who wore a hearing aid.

The practice waiting area was large enough to accommodate patients using wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. There were designated chairs in the waiting room with high backs and arms which enabled patients to sit down and get up independently and safely. However, we saw with the exception of the minor operations treatment area, patient examination couches were not height adjustable. We were told patients used a stool and were assisted by staff during examinations.

Accessible toilet facilities were available for all patients who attended the practice and included baby changing facilities.

The practice had access to a translation service for patients where English was not their first language.

Access to the service

Appointments and telephone consultations were available from 8.45am to 6.30pm on weekdays. Later evening booked appointments until 8pm two days per week were available

Good

Are services responsive to people's needs?

(for example, to feedback?)

for patients unable to attend during routine practice hours. Patients were able to book an appointment and request a repeat prescription via the practice website, by telephone and through the practice dispensary.

Comprehensive information was available to patients about appointments on the practice website and practice booklet. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements in place which ensured patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed then their call was automatically diverted to the out-of- hours provider. Information about the out-of-hours service was provided to patients.

Patients stated they were generally satisfied with the appointments system. Information from the GP National Patient Survey 2013/2014 demonstrated 97% of respondents said their last appointment was convenient. Although all of the patient feedback told us patients were able to get to see or speak to a GP if their appointment was urgent, patients we spoke with said there was a wait of up to three weeks to see the GP of their choice. The practice operated a triage system for urgent appointments. Administrative staff asked simple health related questions of patients. The information was relayed to the duty GP who would telephone the patient back and either offer them an appointment on the day, provide a telephone consultation or prescription based on the patients' history. Staff and some patients told us the system was not always popular however, staff said it enabled more patients to speak to a GP.

All of the patients told us their appointment time often ran late although it was acknowledged this was because the GPs did not rush patients and were thorough. This was confirmed by the GP National Patient Survey 2013/14 where 40% of patients said they waited more than15 minutes for their appointment. This was also confirmed by our observations on the day of the inspection.

Longer appointments were available on request by patients with more than one area of concern and for annual checks for patients with learning disabilities and dementia.

Listening and learning from concerns and complaints

The practice had a system for handling formally recorded complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

The practice had a designated patient liaison manager who managed complaints and liaised with the Patient Participation Group. The practice had received 15 complaints since May 2013 which had been managed in line with the practice policy. Feedback from patients told us they had no complaints about the practice. Patients we spoke with said they were confident any concerns would be managed appropriately. We saw patients could record compliments and minor concerns in a book held in reception which were responded to in a timely manner.

There was information available to patients in the practice leaflet and on the practice website about who to contact in the practice if they wanted to make a complaint. The practice leaflet included information about other organisations to contact if the patient was not satisfied with the way the practice handled their complaint.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care, promote good outcomes for patients and work in partnership with patients. The practice had a comprehensive programme of practice improvements including enhancing patient privacy in waiting areas and reviewing parking arrangements. The practice had appointed a patient liaison lead to expedite patient feedback. Staff we spoke with gave examples of how team work and knowledge of their patients enabled a high standard of care and treatment.

Governance arrangements

The practice had policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We looked at a range of these policies and procedures and saw staff had completed a cover sheet to confirm when they had read the policy. The policies and procedures we looked at had been reviewed and were up to date.

The practice held quarterly governance meetings. We looked at minutes from the meetings and found performance, quality and risks had been discussed. However significant event meeting records were not consistently completed as a learning resource for staff not able to attend the meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at monthly team meetings.

The practice had completed a number of clinical audits, for example, a contraceptive implant audit and an audit of joint injections. Both audits had completed a full audit cycle to demonstrate the effectiveness of the changes made.

The practice had a schedule to assess and update practice risk assessments. The schedule included the frequency and date of assessment. We saw these had been completed on time. Identified risks included display screen equipment, manual handling and sample handling.

Leadership, openness and transparency

There was a clear leadership structure which had named members of staff in lead roles. For example there was a nurse with lead responsibilities for infection control and two GPs had lead responsibilities for safeguarding. Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns.

Staff told us they were well informed of practice issues. We saw there were a range of regular meetings for most teams with the exception of administrative staff. Administrative staff told us it was a challenge to schedule the time they required for a meeting. Team leaders met every month and there were whole practice meetings every six months.

There were protected learning events for all staff every few weeks. Staff told us this was a combination of learning and updates. The practice was closed for these events. Patient queries and appointment times were covered by a duty GP during these closures.

Staff told us they felt well supported. They had access to on-going professional development opportunities.

Quality monitoring records were up to date. We saw evidence of changes to practice resulting from learning from incidents and significant events. Examples included, the recording of patients' vital signs in the event of emergencies and ensuring up to date stock for surgical procedures.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness which were in place to support staff. These were well organised, up to date and reflected current HR procedures.

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

The practice gathered feedback from patients through patient surveys, complaints and the patient participation group (PPG). The results and actions agreed from these surveys were available on the practice website. The practice had an active PPG which had steadily increased in size. The PPG was mostly made up of representatives from patients not working or who had retired. The PPG met every six months with the practice manager and a GP.

Are services well-led?

Good

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

We looked at the results of the PPG annual patient surveys (2014 and 2013) and questions raised by patients to the group. The practice had responded to a range of comments including the use of text messages as appointment reminders and the best use of space in the practice car park. Minutes of meetings demonstrated the survey results were discussed at PPG meetings. The results and actions agreed from these surveys were available on the practice website and as a hardcopy on request. The PPG produced a quarterly newsletter to update patients on practice issues.

Staff told us they were able to give feedback and discussed any concerns or issues with colleagues and management. Overall staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistle blowing policy which was available for all staff to read as guidance.

Management lead through learning and improvement

Staff told us and training records confirmed staff were able to remain updated with mandatory training requirements. We saw continuing professional development opportunities were supported. Staff files demonstrated regular appraisals took place which included a personal development plan. New staff were supported via an induction programme and specific support to orientate and train them for their role. For example, a new member of nursing staff was booked on cervical smear training with a few weeks of commencing in the role. Staff were encouraged to attend protected learning events every two months which they said were educational and informative.

The practice was a GP training practice for GP registrars specialising in primary medical care. Registrars were supported in their role by experienced, trained GPs and received supervision and mentoring throughout their period in the practice.

Learning and improvement regularly took place. For example, the practice had completed reviews of significant events and other incidents and shared with staff who did not attend via hard copy with a covering sheet for signature

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated overall management lead through learning and improvement. For example, audit cycles were completed, action plans were reviewed and communication across the whole staff group took place.