

St Katherines Surgery

Quality Report

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Date of inspection visit: 14 April 2015
Date of publication: 10/09/2015

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

Ratings

Overall rating for this service

Good 

Are services safe?

Good 

Are services effective?

Good 

Are services caring?

Good 

Are services responsive to people's needs?

Good 

Are services well-led?

Good 

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We inspected this service on 14 April 2015 as part of our new comprehensive inspection programme.

The overall rating for this service is good. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. The practice was good at providing services for older people, people with long term conditions, families, children and young people, the working age population and those recently retired, people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from incidents were maximised.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a result of feedback from patients and from the Patient Participation Group (PPG).
- There were systems in place to keep patients safe from the risk and spread of infection.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available for patients should they wish to make a complaint.
- Quality performance data showed the practice was performing highly compared with local and national averages, achieving an overall score of 99.5% in the 2014 to 2015 year.
- The practice held regular multidisciplinary clinical team meetings to discuss the needs of complex patients, for example those with end of life care needs or children who were at risk of harm.
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice had an open culture that was effective and encouraged staff to share their views through staff meetings and significant event meetings.

Summary of findings

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?

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Risks to patients were assessed and well managed. There were robust safeguarding measures in place to help protect children and vulnerable adults. Reliable systems were in place that ensured the safe storage and use of medicines and vaccines within the practice. There was a designated lead to oversee the hygiene standards within the practice to prevent infections. Enough staff were employed by the practice to keep people safe.

Good



Are services effective?

The practice is rated as good for providing effective services. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Data showed that the practice was performing highly when compared to neighbouring practices in the clinical commissioning group (CCG) and nationally. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles. Any further training needs had been identified and appropriate training planned to meet these needs. We saw evidence that appraisals and personal development plans were in place for all staff. Staff worked with multidisciplinary teams internally and externally to deliver positive health outcomes for patients.

Good



Are services caring?

The practice is rated as good for providing caring services. Information from the various surveys we reviewed showed mixed results. Results of the 2014 national patient survey showed the practice was generally rated below average for its satisfaction scores on consultations with GPs and nurses. Feedback from patients during the inspection about their care and treatment was consistently and strongly positive. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care.

Good



Summary of findings

The practice supported patients to have a forum where they could learn and share ideas that promoted their health. There was an active patient participation group (PPG) at the practice that directed its own agenda and focused on topics that mattered to patients. We saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

The practice is rated as good for providing responsive services. The practice understood the needs of the population groups registered with them and were proactive in planning services to meet their needs.

The practice had acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Nationally reported data showed that the practice performed well against indicators relating to the care of older people.

Patients told us they were able to get an appointment with a named GP or a GP of choice, with continuity of care and urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff.

Good



Are services well-led?

The practice is rated as good for being well-led. The practice had a clear vision with the provision of high quality medical care as its top priority. Staff told us they were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles.

The practice had a number of policies and procedures to govern activity. Governance and performance management arrangements had been proactively reviewed and took account of current models

Good



Summary of findings

of best practice. The practice carried out proactive succession planning. Staff told us they were supported to train and develop beyond their roles and move into positions with greater responsibilities. There was good and constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients and it had an active patient participation group (PPG).

There were systems in place to monitor and improve quality and identify risk. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice had discussed the learning that had taken place and the changes to practice that had been made to ensure these were maintained.

The evidence from all these sources showed mixed results from the surveys that had been completed. The practice had worked to improve survey results and ensured that patients were satisfied with the service they received, that they were given enough time during their appointments and that they were treated with care and concern.

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

The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Nationally reported data showed that the practice performed well against indicators relating to the care of older people. For example, the practice maintained a register of patients in need of palliative care. The practice held regular multidisciplinary integrated care meetings where all patients on the palliative care register were discussed.

The practice offered home visits and rapid access appointments for those patients with complex healthcare needs. Patients over 75 years of age were offered annual health reviews.

Good



People with long term conditions

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

Good



Families, children and young people

The practice is rated as good for the care of families, children and young people. Appointments were available outside of school hours and the premises were suitable for children and babies. There were appointments available during the evenings and weekends, seven days a week from 8am to 8pm. The practice also offered a number of online services, including booking and cancelling appointments, requesting repeat medicines, viewing medical records and updating patient details.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk of harm, for example, children and young people who had a high number of attendances at the accident and emergency (A&E) department of the local hospital.

Good



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 needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. There were more appointments available, particularly for working people. These were provided by a company that has been set up by the GPs in Herefordshire to provide additional medical services to patients. There were now three Primary Care Hubs open in the county that provided GP and practice nursing services to all Herefordshire patients during the evenings and weekends, seven days a week from 8am to 8pm.

The practice was proactive in offering a number of online services, including booking and cancelling appointments, requesting repeat medicines and updating patient details. They also provided a full range of health promotion and screening clinics that reflected the needs of this age group. The practice nurses had oversight for the management of a number of clinical areas, including immunisations, cervical cytology and some long term conditions. The healthcare assistants led the smoking cessation clinic in the practice.

People whose circumstances may make them vulnerable

Good



The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including people with a learning disability. The practice was committed to meeting the needs of vulnerable people and provided a caring and responsive service for them. Alerts were placed on these patients' records so that staff were aware they may need to be prioritised for appointments and offered additional attention such as longer appointments.

At the time of the inspection there were 24 patients with learning disabilities on the practice's register and annual health checks had been completed with 21 of these patients. Comprehensive records were kept of these checks and where necessary referrals to other services were made for the patients if they needed additional or more specialised care and treatment.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. They confirmed that vulnerable patients were informed about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff

Summary of findings

demonstrated to us they were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in both normal working hours and out-of-hours.

People experiencing poor mental health (including people with dementia)

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

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

Good



Summary of findings

What people who use the service say

We reviewed 31 patient comments cards from our Care Quality Commission (CQC) comments box that we had asked to be placed in the practice prior to our inspection. We saw that generally most of the comments recorded were extremely positive. Patients commented that they were given excellent care by everyone at the practice and that staff were efficient, very approachable and that nothing was too much trouble. Patients told us that they found the whole experience of the practice to be always very good. The care and attention they received was very satisfactory, they were treated excellently by GPs and staff were always ready to listen to patients and helped them when help was needed. They also commented that they could always see a GP when they needed to. Three patients were less positive and made comments about the problems they experienced in getting appointments when they wanted them. Two other patients commented that had not always been able to see their own GP when they had wanted to.

We spoke with six patients during our inspection. These patients told us they were very satisfied with the treatment they received from all staff at the practice. They told us that they found it easy to make an appointment and that they felt very involved in their care and treatment. They said they were able to ask questions if they needed to. They were also confident that should they have any complaints they would feel able to make one without any comeback.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP Patient Survey dated March 2014 and a survey of patients undertaken by the practice during 2014.

Results of the national survey showed the practice was generally rated below average for its satisfaction scores on appointments with GPs and nurses. Data showed that:

- 60% of patients were satisfied with appointment times, which was comparable with the national average of 80%.
- 65% described their experience of making an appointment as good compared with the national average of 75%.
- 64% would recommend this practice to someone new to the area which compared with national average of 79%.

The practice survey results for 2014 showed that:

- 86% of patients were satisfied with the care they received
- 98% of patients felt that their needs as a patient were met by the practice.
- 87% of patients were always or most of the time able to book an appointment when they needed one.

The results of the NHS Friends and Family Test carried out in May 2015 showed that 90% of respondents were either 'extremely likely' or 'likely' to recommend the practice to a friend or a member of their family.

The evidence from all these sources showed mixed results from the surveys that had been completed. The practice had worked to improve survey results and ensured that patients were satisfied with the service they received, that they were given enough time during their appointments and that they were treated with care and concern.

St Katherines Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and Practice Nurse specialist advisors. The team also included an Expert by Experience who had experience of using this type of service.

Background to St Katherines Surgery

Background to St Katherine's Medical Practice

St Katherine's Medical Practice is located in the market town of Ledbury in Herefordshire and provides primary medical services to patients. The practice covers the market town of Ledbury and surrounding villages stretching over Worcestershire and Gloucestershire borders. The practice has seven GPs including five female GPs, a Foundation Year Two (FY2) doctor, a practice manager and deputy manager, nursing staff including three practice nurses and two health care assistants (HCAs), four administrative and eight reception staff. There were 8,800 patients registered with the practice at the time of the inspection.

The practice is open from 8am to 6pm Mondays to Fridays and is closed at weekends. More appointments are made available, particularly for working people. These are provided by a company that has been set up by the GPs in Herefordshire to provide additional medical services to patients. There are now three primary care hubs open in

the county that provides GP and practice nursing services to all Herefordshire patients during the evenings and weekends. Patients can therefore access GP and nurse appointments seven days a week from 8am to 8pm.

The practice does not provide an out-of-hours service but has alternative arrangements in place for patients to be seen when the practice is closed. If patients call the practice when it is closed, an answerphone message gives the telephone number they should ring depending on the circumstances. Information on the out-of-hours service is provided to patients and is available on the practice's website.

Home visits are available for patients who are too ill to attend the practice for appointments. There is also an online service which allows patients to order repeat prescriptions, book and cancel appointments, update contact details and view parts of their medical record.

The practice treats patients of all ages and provides a range of medical services. The practice provides a number of clinics such as disease management clinics which includes asthma, diabetes, heart disease and lung diseases known as chronic obstructive pulmonary disease (COPD). Other clinics include minor surgery, mental health and dermatology (skin) clinics.

St Katherine's Medical Practice has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

St Katherine's Medical Practice is an approved training practice for training FY2 doctors and has a GP trainer who provides training to newly qualified doctors. The practice also provides medical education for third year, fourth year

Detailed findings

and final year medical students. FY2 doctors are on a two-year, general postgraduate medical training programme which forms the bridge between medical school and specialist/general practice training.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider was 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.

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.

How we carried out this inspection

How we carried out this inspection

Before our inspection of St Katherine's Medical Practice we reviewed a range of information we held about this practice and asked other organisations to share what they knew. We contacted Herefordshire Clinical Commissioning Group

(CCG) and NHS England Area Team to consider any information they held about the practice. We also supplied the practice with comment cards for patients to share their views and experiences of the practice.

We carried out an announced inspection on 14 April 2015. During our inspection we spoke with a range of staff that included four GPs, the practice manager, nursing, administration and reception staff. We also looked at procedures and systems used by the practice.

We observed how staff interacted with patients who visited the practice. We spoke with six patients who visited the practice during the inspection. We reviewed 31 comment cards where patients and members of the public shared their views and experiences of the practice.

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

- 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 patients and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People whose circumstances may make them vulnerable
- People experiencing poor mental health

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. We reviewed safety records, incident reports and minutes of meetings where these were discussed. These records showed the practice had managed these consistently over time and could show evidence of a safe track record over the year.

Staff told us they were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, where a patient had requested a copy of their test results and had been given the results of another patient in error, we saw that action had been taken in response to this. A revised procedure was established to ensure there was no recurrence. We saw that significant events had been discussed at practice meetings which demonstrated the willingness by staff to report and record incidents. For example, we saw that an incident which involved a failure of the cold chain procedure had been investigated and changes made to the procedures to reduce the risk that similar incidents occurred.

Learning and improvement from safety incidents

The practice had system in place for recording, responding to, monitoring and reviewing significant events. There were records available to show significant events that had occurred over several years. We reviewed those that had occurred during the last 12 months. We tracked four such incidents and saw that records had been completed promptly in a comprehensive way. For example, we saw that an event about miscommunication with a patient that occurred June 2014 had been analysed with action taken recorded. We saw that a date for review had been set and completed, with no further action identified. Another significant event had analysed the way events had been handled when a patient had become unwell at the practice. We saw that learning had been established from this event and changes had been made to procedures that staff were to follow in the event a similar incident was to occur at the practice.

We saw that significant events were discussed at the weekly practice meetings and minutes were circulated to staff. There was evidence that the practice had learned

from these and that the findings were shared with relevant staff. Staff, including receptionists and nursing staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We saw evidence that showed patients were told about significant events on an individual basis.

The practice had a safety alert protocol and procedure in place which we saw had been reviewed in March 2015. National patient safety alerts were disseminated by the practice manager to practice staff. Staff we spoke with gave us examples of recent alerts that were relevant to the care they were responsible for, such as a recent alert which concerned diabetic testing machines. They also told us that alerts were discussed at the practice meetings to make sure all staff were aware of any that were relevant to the practice and any action that was needed. A log was kept of all the alerts by the practice manager to indicate whether or not action had been required.

The practice was also prepared to share their experiences and learning on a wider scale. For example, we saw that learning from the cold chain incident that had occurred had been shared with the Clinical Commissioning Group (CCG) so that their learning could be shared with other practices in the CCG area.

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 safeguarding policies in place for both adults and children. We saw that both these policies had been reviewed during 2015. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible for staff.

The practice had a dedicated GP as the safeguarding lead for vulnerable adults and children. They had been trained and could demonstrate they had the knowledge and understanding to enable them to fulfil this role. All staff we spoke with told us they were aware who the lead was and

Are services safe?

who to speak within the practice if they had a safeguarding concern. Staff gave us an example of an incident that had occurred at the practice that they had escalated to the GP lead as a child protection concern. All procedures had been followed and although staff told us there had been no further action on that occasion, they confirmed that they would continue to report other concerns should they have any.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments, for example children who were at risk of harm and or registered on a child protection plan. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as health visitors and social services.

There was a chaperone policy available to all staff on the practice computer system. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. Clinical staff we spoke with told us they acted as chaperones when needed. They confirmed they had received chaperone training and they were clear about their responsibilities. This included, for example knowing where to stand when intimate examinations took place. We saw staff training records to confirm this. The practice manager told us that reception staff that were willing to act as chaperones had been given training to do this and appropriate security checks had been completed accordingly. The training had included discussion on the type of examination, what to observe and what was required of a chaperone.

Information about a chaperone service was provided for patients on the practice's website, in reception and in the waiting room to inform patients of this facility. GPs told us they offered the chaperone service to patients and where chaperones were used details had been recorded on patient records. GPs had not however, recorded when a chaperone service had been offered but declined. The GPs addressed this during the inspection and confirmed that in future where patients declined a chaperone they would ensure this was recorded.

Medicines management

The practice had a medicines management policy in place which had been reviewed and updated on 10 April 2015. We checked medicines stored in the treatment rooms and

medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures which described the action to take in the event of a potential failure. The practice staff were seen to follow the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw that logs were kept of checks carried out, that included the quantity of the medicines held and their expiry dates. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. The health care assistants (HCAs) administered vaccines and other medicines using directions that had been produced by the prescriber. We saw evidence that nurses and the HCAs had received appropriate training and been assessed as competent to administer the medicines by the prescriber.

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. We saw that regular audits of the prescription pads were carried out to ensure that all prescriptions could be accounted for.

Data showed that the practice was one of the consistently high performers on quality indicators with low prescribing rates for antibiotic, antidepressant and hypnotic medicines. We saw records of practice meetings that noted the actions taken in response to reviews of prescribing data. For example, data from 2014 showed that for the period April 2013 to end of March 2014 the practice was rated as 11% for prescribing of hypnotic medicines compared with 28% for the national average. The practice was also rated as 2% for the prescribing of antibiotics compared with national average of 28%. Meeting minutes showed the practice regularly discussed prescribing to increase awareness within the team, to maintain prescribing rates and to promote further reductions in prescribing where appropriate for patients and the practice.

Are services safe?

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice employed a company to carry out the cleaning of the premises. Cleaning schedules were in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. Patients told us through the comment cards that they always found the practice to be clean and hygienic and that they had no concerns about a risk of infection.

One of the practice nurses was the lead for infection control and all staff had received infection control training with annual updates. 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. This policy had been reviewed in February 2015. For example, personal protective equipment including disposable gloves, aprons and coverings for examination couches were available for staff to use and staff described to us how they would use these to comply with the practice's infection control policy.

We checked the records that were kept by the practice to show the Hepatitis immunity status for staff working at the practice. Records for clinical and non clinical staff were kept and all records were up to date.

There was also a policy and guidance in place for needle stick injury and staff knew the procedure to follow in the event of an injury. The policy was available for staff online and guidance for staff was also clearly displayed in treatment rooms. 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 saw that infection control audits were carried out by the infection control lead. An audit of the practice had been scheduled for 16 April 2015. The previous audit had been carried out on 7 February 2014. From this audit we saw that issues of concern had been recorded, with action taken to resolve these. For example, all posters on cupboard doors in clinical areas, toilets and baby changing area were required to be laminated to facilitate cleaning. We saw evidence that all posters were now laminated throughout the practice.

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 that confirmed the practice carried out regular checks in line with this policy to reduce the risk of infection to staff and patients. A comprehensive risk assessment had also been carried out by a company employed by the practice in June 2014.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested by a company that was employed by the practice. They carried out testing on equipment and we saw labels indicating the last testing date of 29 November 2014 displayed on equipment.

Records confirmed that measuring equipment used in the practice was checked and calibrated each year to ensure they were in good working order. For example, we saw that annual calibration (testing for accuracy) of relevant equipment such as weighing scales, ear syringes, nebulisers and blood pressure monitoring machines had been carried out during 2014.

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 the appropriate professional body 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. This included the completion of a risk assessment for non-clinical staff where DBS checks were not required. However, where staff had carried out chaperone duties DBS checks had been completed. We spoke with staff who confirmed that all these checks had been carried out prior to their employment.

The practice told us there had been some significant changes to the staffing arrangements in the practice throughout last year. They had carried out a full review of the staffing needs for the practice to make sure there were sufficient and appropriate staff available at all times. We spoke with staff about the arrangements for planning and monitoring the number of staff and mix of staff needed to

Are services safe?

meet patients' needs. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. They told us they were flexible and covered for each other and would work additional hours if required. The practice manager told us they carried out staffing comparisons with other practices in the area every six months and reported their staffing levels to the Clinical Commissioning Group (CCG). They told us that this had enabled them to increase staffing levels at the practice over the last few years to ensure they were staffed appropriately that ensured patients safety that was also comparable with other local practices.

The practice told us they used a small group of locum GPs and although they had no specific Service Level Agreement (SLA) in place for these locums they had followed their recruitment policy and procedures. They had carried out employment checks according to their policy and procedures and we saw evidence to confirm this.

Monitoring safety and responding to risk

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

The GPs and practice manager told us there were sufficient appointments available for high risk patients, such as patients with long term conditions, older patients and babies and young children. Patients were offered appointments that suited them, for example the same day, next day or pre-bookable appointments with their choice of GP.

Staff told us they were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, staff explained how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

There was a system in place that ensured patients with long term conditions were invited for regular health and medicine reviews and contact was made to follow up on patients where they failed to attend. The practice told us

that patients were offered extended appointments with an appropriate clinician. Patients with diabetes were given health and medicine reviews twice yearly to ensure all opportunities to help the patient manage their conditions were taken. A monthly clinic was held at the practice with the diabetic specialist nurse for patients with more complex needs.

Two practice nurses were trained and experienced in providing health care for patients with a respiratory disease. Patients were encouraged to take an active role in managing their condition. Nurses told us they promoted patient self-management of their conditions and provided patients with information to assist them in doing so. The practice also regularly audited overuse of inhalers in an effort to identify those patients at risk of acute hospital admission and invited patients in to discuss their respiratory disease with a GP or nurse.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw evidence that basic life support training had been completed by all staff including reception staff. Emergency equipment was available including access to oxygen and an automated external defibrillator (a machine used to attempt to restart a person's heart in an emergency). Staff we spoke with all knew the location of this equipment and records confirmed that it was checked regularly so that it was suitable for use.

Emergency medicines were available in a secure area of the practice and staff spoken with knew of their location. These included medicines for the treatment of cardiac arrest (where the heart stops beating), a severe allergic reaction and low blood sugar. 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, loss of telephone system, loss of computer system, GP sickness and annual leave, and loss of clinical supplies. The document also contained relevant contact details for staff to refer to which ensured the service would be maintained during any emergency or major incident. For example, details of local suppliers to contact in the event of failure, such as heating and water suppliers. We saw there was a

Are services safe?

procedure in place to protect computerised information and records should there be a computer systems failure. The practice manager and GPs confirmed that copies of this plan were held off site with designated management staff.

We saw that fire safety procedures were in place. A risk assessment had been completed on 20 March 2015 and issues had been identified. For example, the risk

assessment found the fire exit door was blocked where the rubbish was stored and two fire doors were found wedged open. The practice had acted on these to ensure they met fire regulations and regular checks had been carried out to ensure there were no recurrences. Records also showed that staff were up to date with fire training and that they practised regular fire drills.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We found from our discussions with the GPs that they completed assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate.

The lead practice nurse accessed NICE guidance and printed out information for all clinical staff to sign when read. Shared records were in place to enable best practice guidance to be stored and shared by all staff. We saw copies of the guidance that had been circulated to clinical staff by email and minutes of practice meetings where new guidelines had been discussed and shared. Staff confirmed that changes to guidance had been discussed during practice study time.

GPs at the practice each led in specialist clinical areas such as diabetes, palliative care, mental health, learning disabilities, dementia, women's health, lung diseases such as asthma, and minor surgery. The practice nurses supported this work, which allowed the practice to focus on the specific conditions. The GPs attended educational meetings facilitated by the Clinical Commissioning Group (CCG) and engaged in annual appraisal and other educational support. The annual appraisal process required GPs to demonstrate that they had kept up to date with current practice, evaluated the quality of their work and gained feedback from their peers. Clinical staff told us they ensured best practice was implemented through regular training, networking with other clinical staff and regular discussions with the clinical staff team at the practice. We were told that GPs were very approachable and that clinical staff felt able to ask for support or advice if they felt they needed it.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that they encouraged a culture in the practice of patients cared for and treated based on need. The practice took account of patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

The practice routinely gathered information about people's care and treatment and monitored this information in order to improve patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients such as data input, scheduling clinical reviews, managing child protection alerts, medicines management, prescriptions management and infection prevention and control.

The practice had a system in place for completing clinical audits. Clinical audits are quality improvement processes that seek to improve patient care and outcomes through systematic review of care and the implementation of change. It includes an assessment of clinical practice against best practice such as clinical guidance to measure whether agreed standards were being achieved. The process requires that recommendations and actions are taken where it is found that standards are not being met.

The practice showed us four clinical audits that had been completed. Following each clinical audit, changes to treatment or care had been made where needed to ensure outcomes for patients improved. For example, one of the audits had reviewed the prescribing of a particular medicine. The initial audit was carried out in September 2013 with a re-audit in December 2013. This audit found some improvements had been made. Audits clearly showed the rationale, the results and the proposed changes to be made, with dates for follow up audits scheduled.

The practice told us that the local CCG had introduced the program of monitoring and audit assessment called Quality, Innovation, Productivity and Prevention (QIPP). The aim of the QIPP programme was to improve efficiency which would lead to improved quality of care. One of the areas measured through the QIPP programme was antibiotic prescribing, which was already low for this practice. For example, the prescribing rate for the practice for one antibiotic medicine was 2.24% which was significantly lower than the national average of 5.57%. GPs told us they continued to review their prescribing practices through discussion at practice meetings. We saw meeting minutes that confirmed this.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) which compared performance against national screening programmes to

Are services effective?

(for example, treatment is effective)

monitor outcomes for patients. QOF is a national performance monitoring tool. In most areas the practice had reached performance levels that were comparable with the national average. For example, the number of patients diagnosed with dementia whose care had been reviewed in the preceding 12 months was 84% which compared with the national average of 83%. The practice had achieved 97.5% for their total QOF points compared with a national average of 94%.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as patients with a learning disability. The practice carried out structured annual reviews for patients with long term conditions.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. Staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year. For example, a contraceptive implant audit for 2014 had highlighted the importance of post procedural follow up checks being carried out for all patients. The audit had showed that two patients who had not attended for follow up appointments had experienced some minor complications following their treatment. The practice had implemented a recall procedure specific to this group of patients as a result of the findings of the audit.

There was a protocol in place for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for patients with long-term conditions, such as diabetes and that the latest prescribing guidance was being used. The computer system used at the practice flagged up relevant medicine alerts when the GP prescribed some medicines. We saw evidence to confirm that, after receiving an alert the GPs had reviewed the use of the medicine in question and, where they continued to prescribe these outlined the reason why they had decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice operated the Gold Standards Framework (GSF) for all palliative care patients. The GSF is a practice based system to improve the quality of palliative care in the community so that more patients received supportive and dignified end of life care, where they chose. The practice held three-weekly palliative care meetings with Macmillan and district nurses to review all aspects of care for patients who were on their palliative care register. The team also arranged to contact bereaved relatives to provide on-going support. Staff told us that an alert was added to the notes of any bereaved relatives to support this.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with training such as annual basic life support. We noted a good skill mix among the GPs who collectively had specialist interests as medical education trainers, in women's health and paediatrics. All 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 the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses and health care assistants (HCAs) had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology, ear syringing, quit smoking programme and lifestyle advice. Those with extended roles as in monitoring patients with long-term conditions such as asthma, diabetes and heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

St Katherine's Medical Practice was approved to provide medical training. The practice considered the provision of medical education to be one of their strengths. The practice had a qualified GP trainer who provided educational support at the practice.

Are services effective?

(for example, treatment is effective)

Medical education was provided to third year, fourth year, final year medical students and Foundation Year Two doctors (FY2). This scheme supported newly qualified doctors onto a programme structure of diagnosis and management of patients not only in hospitals but also in mental health and general practice. These doctors had at least 12 months of experience in hospital medicine after qualifying before they moved to general practice. FY2 Doctors were placed with a practice for four months and had their own surgery when they saw patients. They were supervised by the practice's GP trainer during their experience of working in general practice.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. It received blood test results, x-ray results and letters from the local hospital including discharge summaries and the out-of-hours GP services, both electronically and by post. The practice worked with a company that has been set up by the GPs in Herefordshire to provide additional medical services to patients. There were three Primary Care Hubs open in the county that provided GP and practice nursing services to all Herefordshire patients during the evenings and weekends, seven days a week from 8am to 8pm.

The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings monthly (or sooner if required) to discuss the needs of complex patients, for example those with end of life care needs or children at risk of harm. These meetings were attended by health visitors and palliative care nurses. Decisions about care planning were documented in the patient's record. Staff told us this system worked well. GPs told us that they worked closely with the team to make sure patients' needs were met and that important information was shared. Staff also told us that members of the community team such as health visitors, district nurses, mental health nurse and a psychiatrist were available when they held their clinics in the practice's building should there be information they wanted to share or had concerns they wanted to raise ahead of the usual meetings.

The practice met every three weeks with the Macmillan team and district nurses to review patient care, patients that had died, and discussed overall care and patient wishes such as their place of death. We saw minutes of a meeting that had taken place in October 2014 with district nursing managers to discuss the level of service that was to be provided for patients locally.

We saw CCG data for the year end March 2015 which showed that patients registered with the practice were one of the lowest attenders of accident and emergency (A&E) in the CCG area. GPs told us they reviewed each patient who attended A&E to ensure that their attendance could not have been addressed by the practice.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP extended hours provider to enable patient data to be shared in a secure and effective manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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 and told us that the system was safe and easy to use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Notes from GPs attending to patients out of hours were faxed or emailed through to the practice the following morning. The extended hours company had access to patient records. The practice manager told us there was a data sharing agreement in place for the extended hours service and an information sharing protocol was in place with the palliative care team to facilitate this.

The practice made referrals directly and through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported that this system was easy to use and worked well.

Are services effective?

(for example, treatment is effective)

The practice held regular meetings with other agencies to share information. For example, regular meetings were held with the palliative care team every three weeks and monthly meetings were held with the multi-disciplinary teams (MDTs) to review care for patients.

Consent to care and treatment

We saw that the practice had a policy for documenting consent. We found that clinical staff we spoke with were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. GPs told us they recorded decisions about consent and capacity in patient records and showed us an example that had been anonymised to demonstrate this. The GPs we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance. They confirmed they accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

Care plans were in place for patients with learning disabilities and those with dementia. Patients were involved in agreeing these care plans and a section was available stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. The GPs also demonstrated a clear understanding of Gillick competence. The 'Gillick Test' helped clinicians to identify children under 16 years of age who had the legal capacity to consent to medical examination and treatment.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a patient's written consent was documented and then scanned into the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure where applicable. The clinical staff we spoke with understood the key parts of the legislation and they were able to describe to us how they implemented it in their practice. For example, staff told us consent was sought prior to the administering of immunisations and was documented in the patient's record. We saw from training records that clinical staff had completed training in consent. An audit completed in 2014 on minor surgical procedures had included checks on whether there had been a clear record that informed consent had been obtained in the patients' medical records. The audit found that in all but one case there had been a clear record of

informed consent obtained in the medical record. In July 2014 the practice introduced a written consent form in an attempt to standardise the information given to patients before the procedure was carried out.

The practice had not needed to use restraint but staff told us they were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

It was practice policy to offer a health check with one of the nurse practitioners to all new patients registering with the practice. CCG data showed that the practice had one of the highest uptakes in the county for NHS Health checks. Clinical staff told us if any health concerns were detected during the health checks the GP would be informed and these would be followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by promoting the benefits of childhood immunisations with parents or by carrying out opportunistic medicine reviews.

Staff told us they aimed to provide good chronic disease management, with patient education as the key to improvements in patient health. They told us that giving patients adequate guidance and education helped them to manage their own health. Information was available for patients on the practice's website and in the practice reception and waiting areas.

The practice had numerous ways of identifying patients who needed additional support and it was pro-active in offering help. For example, the practice kept a register of all patients with a learning disability and ensured that longer appointments were available for them when required. Annual health reviews were also carried out for patients with a learning disability and saw that 21 of the 24 patients registered with the practice had been completed.

The practice nurses we spoke with told us they carried out regular health checks of patients with range of long term conditions. They confirmed that meetings were held with the palliative care teams to ensure co-ordinated care was provided to patients that matched their needs and wishes.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. Clinical staff described the policy and procedure in place for following up patients who failed to attend by either the named practice nurse or the GP. The practice

Are services effective?

(for example, treatment is effective)

offered flu vaccinations to patients over the age of 65 and to patients with chronic diseases such as asthma, diabetes, heart disease, and kidney disease. For example, last year's performance for patients with diabetes who had received the flu vaccine at 91% was higher than the national average of 86%.

The practice also offered NHS Health Checks to all its patients aged 40-75 years of age. The NHS Health Check programme was designed to identify patients at risk of developing diseases including heart and kidney disease, stroke and diabetes over the next 10 years. GPs and clinical staff showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and described how they scheduled further investigations.

Up to date care plans were in place that were shared with other providers such as the out-of-hours provider and with multidisciplinary case management teams. Patients aged 75 years or over and patients with long term conditions were provided with a named GP.

Last year's performance for cervical smear uptake was 91%, which was higher than the national average of 82%. There

was a policy to offer telephone reminders for patients who had not attended for cervical smears and the practice carried out annual audits for patients who failed to attend. We saw that cytology training had been completed by the nurses who carried out cervical smear tests.

We saw that a range of health promotion leaflets were available in the reception area, waiting room, treatment rooms and on the practice's website. Clinical staff we spoke with confirmed that health promotion information was available for all patients. They told us that they discussed health issues such as smoking, drinking and diet with patients when they carried out routine checks with patients. Staff told us that patients could also take part in the local health programme in conjunction with the local gym. This was available free of charge for a period of 12 weeks to train with health trainers.

Staff confirmed that patients were given information to access other services as was needed, such as the bereavement service Cruse. We saw that the practice had access to a range of support organisations that they were able to signpost patients to for further information

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction, taken from the national patient survey 2014 and complaints and compliments received by the practice. We also looked at the 31 Care Quality Commission (CQC) comment cards patients were invited to complete to provide us with feedback on the practice. We spoke with six patients who attended the practice during our inspection. The evidence from all these sources showed that patients were generally satisfied with how they were treated and confirmed that this was with respect, dignity and compassion.

Information from the various surveys we reviewed showed mixed results. For example, results of the 2014 national patient survey showed the practice was generally rated below average for its satisfaction scores on consultations with GPs and nurses. The practice had worked to improve survey results to ensure that patients were satisfied with the service they received, that they were given enough time during their appointments and that they were treated with dignity, care and concern. The practice carried out a survey as a result of feedback from the national survey. The results showed that 86% of patients were satisfied with the care they received and that 98% of patients felt that their needs as a patient were met by the practice.

We looked at each of the 31 comment cards completed by patients who told us what they thought about the practice. All comments were extremely positive about the service experienced. Patients had commented that staff were efficient, very approachable and that nothing was too much trouble. Patients told us that they found that the whole experience of the practice was always very good and that care and attention was very satisfactory, treated excellently by GPs, staff were always ready to listen to patients and helped them when help was needed.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We saw the rooms had appropriate couches for examinations and curtains to maintain privacy and dignity during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Staff told us that if patients wanted to speak to the receptionist or practice manager privately they would be taken to a private room. Staff told us they were required to register with another practice locally for their medical care. They also had restricted access to electronic records for any relatives registered with the practice to protect their relative's confidentiality.

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

Observation of and discussions with staff showed that they were compassionate and treated patients in a sensitive manner, particularly important for those patients whose circumstances may make them vulnerable such as temporary residents or patients who were experiencing mental health issues.

Staff told us they offered a chaperone service if patients preferred. We saw leaflets in the reception area and information on the practice website that confirmed this. Clinical staff confirmed they had received chaperone training. They told us that information was made available to patients to inform them that a chaperone option was available to them.

There was information in the practice information leaflet and on the practice's website stating the practice's zero tolerance for abusive behaviour. Staff told us that there had been occasions when they had needed to refer to this to diffuse potentially difficult situations, but this had only been necessary on a small number of occasions. We saw a sign positioned at the entrance door advising patients of the policy.

Care planning and involvement in decisions about care and treatment

The national patient survey information we reviewed showed patients were generally satisfied about their involvement in planning and making decisions about their care and treatment. Data from the national patient survey 2014 showed that 73% of practice respondents said the GP involved them in care decisions and 75% felt the GP was

Are services caring?

good at treating them with care and concern. These results were slightly below the national averages. The practice was concerned about these scores and carried out a practice survey during 2014. The results showed that 86% of patients were satisfied with the care they received and 98% of patients felt that their needs as a patient were met by the practice.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also positive and aligned with these views. Patients' commented that all clinical staff at the practice took the time when they attended for treatment and made sure they fully understood their treatment options.

We saw evidence of care plans and patient involvement in agreeing these. For example, patients with a learning disability were given longer appointments so that they could be given time to discuss their individual care plans. Other patients such as those who were diagnosed with asthma, dementia and mental health concerns also had individual care plans. Staff demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Staff told us that they always encouraged patients to make their own decisions. They told us that they would always speak with the patient and obtain their agreement for any treatment or intervention even if they were with a carer or relative. Nurses told us that if they had concerns about a patient's ability to understand or consent to treatment, they would ask their GP to review them.

The practice was able to evidence joint working arrangements with other appropriate agencies and

professionals. For example, palliative care was carried out in an integrated way. This was done using a Multidisciplinary team approach with district nurses, palliative care nurses and hospitals.

Patient/carers support to cope emotionally with care and treatment

Feedback from patients showed that they were positive about the emotional support provided by the practice. For example, patients wrote in the comment cards that they thought the practice was excellent and staff always seemed to go out of their way to give them the help they needed. They commented that staff were caring and supportive throughout. Comments from other patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this feedback. Patients told us that staff responded compassionately and provided support when required.

Notices and leaflets in the patient waiting room told patients how to access a number of support groups and organisations. Leaflets were available in the reception area and included details about benefits and useful contacts for all carers. The practice had a carer's lead and actively promoted registration with Herefordshire Carers Support to help facilitate support. Patients who were also carers were coded on the practice's computer system so that this was kept under consideration during consultations.

Staff told us that if families had suffered bereavement, they were given advice on how to find a support service for example CRUSE the national bereavement charity. The practice had a policy of following up on families where there had been a bereavement.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs of patients in the way services were delivered. Staff told us the practice population consisted of a higher number of older patients. For example, national patient data showed that the number of patients in the over 65 years of age population group registered with the practice was 25% compared with the national average of 17%. The population group of patients over 75 years of age registered with the practice was 12% compared with the national average of 8%.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice regularly engaged with them and other practices to discuss local needs and service improvements that needed to be prioritised. GPs told us they attended these quarterly meetings and shared information with practice staff where actions had been agreed to implement service improvements and manage delivery challenges to its population.

The practice delivered core services to meet the needs of the patient population they treated. For example, screening services were in place to detect and monitor the symptoms of long term conditions such as asthma and lung disease. They explained they also used these sessions to give dietary advice and support for patients on how to manage their conditions. Longer appointments were available for patients who needed them such as patients with mental health concerns, learning disabilities and long term conditions.

The practice had a palliative care register and regular three-weekly multidisciplinary team meetings (MDTs) were held to discuss patient and their families care and support needs. We were told by staff that the MDTs worked very well as a team to provide care for all patients.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. For example, the

PPG report for 2014 identified that improvements were needed in how the practice communicated with patients. The PPG was involved in the development of a public relations campaign to tell patients about the practice and what they offered. An article had been added to the practice website and included in the practice newsletter to explain the appointment system and how patients could get the best from it.

The practice GPs were strongly involved and engaged with their local clinical commissioning group (CCG). They were keen to be involved in local initiatives and in sharing good practice. GPs told us about and we saw evidence of engagement with the CCG. For example, the practice had agreed with the CCG to open on Easter Saturday to meet patients' needs.

We saw that the practice was responsive to wider learning from other experiences. For example, the practice decided to carry out an audit in 2014 on adolescent diabetics in response to a serious case review that had taken place within the CCG area. This had concerned a patient who had died from complications related to diabetes. The practice recognised that this provided an appropriate rationale for carrying out an audit on patients registered with the practice. The practice found there were six patients registered at the practice and that 50% of them had a poor compliance rate with attendance for reviews of their condition. The practice discussed the findings and agreed a recall protocol for those difficult to engage patients to increase review and monitoring attendance at the practice. A re-audit had not been completed at the time of the inspection to determine the effectiveness of the changed recall protocol.

Systems were in place to assess and manage the care of patients with long term conditions such as diabetes, asthma and lung diseases such chronic obstructive pulmonary disease (COPD). Specialist visiting nurses held clinics at the practice for patients with diabetes, learning disabilities and mental health concerns.

Tackling inequity and promoting equality

The practice proactively removed any barriers that some patients faced in accessing or using the service. They worked with visiting specialist nurses to engage with patients with for example, dementia or a learning disability in a positive way to help them manage their conditions.

Are services responsive to people's needs?

(for example, to feedback?)

Five female GPs worked at the practice and were able to support patients who preferred to see a female doctor. This also reduced any barriers to care and supported the equality and diversity needs of the patients.

There were arrangements in place to ensure that care and treatment was provided to patients with regard to their disability. For example, the practice building was at ground floor level and patients had ease of access to various areas of the practice building. Doors were wide enough for patients in wheelchairs to gain access. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice. There was a hearing loop available and a dropped counter for patients in wheelchairs so they were able to access the reception counter.

The practice had recognised the needs of different groups in the planning of its services such as carers and vulnerable patients who were at risk of harm. The computer system used by the practice alerted GPs if patients had a learning disability, or if a patient was also a carer so that additional appointment time could be made available. Where patients were also identified as carers we saw that information was provided to ensure they understood the support that was available when needed.

Staff told us that translation services were available for patients who did not have English as a first language. This service could be arranged to take place either by telephone or in person.

The practice was signed up to the learning disability direct enhanced service (DES) to provide annual health checks for their patients with a learning disability. The service was intended to reduce the incidence of the presence of one or more additional disorders and premature deaths for people with learning disabilities. The DES encouraged practices to identify patients aged 14 and over with the most complex needs and offer them an annual health check as well as a health action plan. As part of this service, the practice maintained a register of patients with learning disabilities. For the 2014 to 2015 year there were 24 patients on the register and an annual health check had been completed with 21 of them.

The practice had an equality and diversity policy in place which had been reviewed in April 2014. The practice

provided equality and diversity training through e-learning. Clinical staff we spoke with confirmed that they had completed this training in the last 12 months. We saw training records that confirmed this training had been completed.

Access to the service

The practice was fully equipped and purpose built with easy access for for patients who used wheelchairs. The practice was situated within the Community Hospital complex. There was provision for patients with a hearing impairment at the practice. We saw signs within the waiting area to indicate a hearing loop was available; there was a screen which provided visual prompts for patients to be aware that they were being called for their appointment and staff told us that longer appointments would be made for patients with a hearing impairment.

Staff told us that translation services were available for patients who did not have English as a first language. This service was available either by telephone or in person. The practice told us that over the past 10 years they had attracted an increasing number of people who had English as a second language, many of whom have travelled from Eastern Europe to work in agriculture. The practice told us they had good relationships with the local fruit farms providing the managers with information on all services to encourage their staff to register locally. The practice had access to Herefordshire Language Link who provided translator services free of charge to patients and the practice pre-booked longer appointments to facilitate this.

Comprehensive information was available to patients about appointments on the practice website. This included details on how to arrange urgent appointments and home visits. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. There was an answerphone message which gave the telephone number patients should ring depending on their circumstances. Information about the out-of-hours service was provided to patients in leaflets, through information displayed in the waiting room and on the practice website.

The practice was open from 8am to 6pm Mondays to Fridays and was closed at weekends. More appointments were made available, particularly for working people. These were provided by a company that has been set up by the GPs in Herefordshire to provide additional medical services to patients. There were three Primary Care Hubs

Are services responsive to people's needs?

(for example, to feedback?)

open in the county that provided GP and practice nursing services to all Herefordshire patients during the evenings and weekends. Patients could therefore access GP and nurse appointments seven days a week from 8am to 8pm.

The practice does not provide an out-of-hours service but had alternative arrangements in place for patients to be seen or ensured that patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients and was also available on the practice's website.

Home visits were available for patients who were too ill to attend the practice for appointments. There was also an online service which allowed patients to order repeat prescriptions, book and cancel appointments, update contact details and view parts of their medical record. Some of the feedback comments we received from patients told us that they found the online booking system and telephone consultations for patients helpful.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We found that there was an open and transparent approach towards complaints. Accessible information was provided to help patients understand the complaints system on the practice's website and in a complaints leaflet available at the practice. The patients' complaints leaflet also included information for Herefordshire Patient Advice and Liaison Service (PALS) and complaints. PALS aimed to help patients with queries about GPs and other services, as well as local hospitals. The information advised patients that PALS would listen and respond to concerns, suggestions and queries, as well as using feedback to help improve the services.

Patients recorded on comment cards that they were aware of the process to follow should they wish to make a complaint. None of the patients had ever needed to make a complaint about the practice. Staff told us that they were aware of the action they should take if a patient complained. Staff confirmed that complaints were discussed at practice meetings and they were made aware of any outcomes and action plans in place to address changes needed. We saw minutes that confirmed these discussions had taken place.

We saw that the practice had recorded all complaints, including verbal and written complaints. Annual reviews of complaints had been carried out to identify themes or trends. We looked at the review for the period April 2014 to end of March 2015. The practice had received 10 complaints during this period and responses to and outcomes of complaints had been clearly recorded.

We tracked four complaints and found the practice responded to these and learning identified had been recorded where appropriate. For example, we saw where a complaint had been made by a relative of a patient who was housebound. The patient had received letters requesting attendance for various clinics despite the practice having knowledge that the patient was unable to attend for clinics. The complaint had been investigated and found that despite the computer system showing the patient as housebound, the member of staff had failed to notice this. To address this, the practice had placed an alert on the patient's record to ensure further appointment letters were not sent to them. There had been no further occurrences reported.

We saw evidence that showed lessons learned from individual complaints had been acted on and included for example, further training needs where they had been identified. The annual review shared overall learning from the complaints with all staff members to ensure that learning continued to be shared and reviewed in an open and responsive way.

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 sent us a copy of their statement of purpose prior to the inspection of the service. This told us that their aims were to provide a high standard of medical care, to act with integrity and confidentiality, to be committed to their patients needs, to treat all patients and staff with respect, honesty and dignity, and ensure a safe and comfortable environment for patients and staff.

We saw that the practice charter included statements regarding patient care, treating patients with respect and staff training. The charter also included statements on patients' responsibilities such as cancelling appointments if they were unable to attend them.

The practice had undergone some significant changes during the last year which had included changes to their structure and management of the practice. Staff told us they held an away day last year to consolidate these changes. The practice told us they planned to refurbish the premises, particularly the reception and waiting areas, the provision of two additional consulting rooms and audio visual teaching equipment. The practice told us this was part of their longer term vision to offer more and introduce new services for patients, and improve working conditions for staff. Staff we spoke with were aware of this vision and showed a strong commitment to work to provide this level of service for all patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on their computer desktop within the practice. We looked at eight of these policies and saw that these had been reviewed and updated regularly.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. QOF is a national performance measurement tool. The QOF data for this practice showed that in all relevant services it was performing above or in line with national standards. We saw that QOF data was regularly discussed at weekly meetings and action taken to maintain or improve outcomes.

We saw that regular practice meetings were held that enabled decisions to be made about issues affecting the general business of the practice. All staff were encouraged

to attend these meetings. Recordings were made of the meetings and any actions required were clearly set out and reviewed to ensure changes were made. Staff told us they could make suggestions for improvements and that they were treated as equals by senior staff.

The practice had arrangements for identifying, recording and managing risks. We saw evidence where risk assessments had been carried out which identified key risks, with action plans in place to manage and minimise these risks. Risks identified included fire and health and safety at work. We saw from minutes of meetings that performance, quality and risks had been discussed and actions had been taken to address any improvements where they had been identified.

Leadership, openness and transparency

At the start of the inspection the practice gave us a presentation on the services they provided. We observed the leadership roles in action and the team approach to the presentation. The practice supported the inspection in a friendly, open, supportive and welcoming way.

GPs confirmed there were positive relationships between the partners and the management to deliver patient centred quality care. There was a clear, visible leadership and management structure in place with responsibility for different areas shared amongst GP partners. For example, all the partners had various lead responsibilities such as safeguarding, palliative care, family planning and minor surgery leads. Clinical staff also had lead roles such as the lead nurse for infection control. We spoke with six members of staff and they were all clear about their own roles and responsibilities. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. Staff told us they felt very much supported by everyone at the practice.

We found the practice to be open and transparent and prepared to learn from incidents and near misses. Weekly practice meetings were held where these were discussed. Lessons learned from these discussions were shared with the team. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff confirmed that information was shared with them.

Staff told us that the practice was well led. All members of the management team were visible and accessible. Records showed that regular meetings took place for all

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staff groups. The practice manager told us that they met with the GPs each week and information from those meetings was shared with staff. Staff told us that the GPs and the practice managers were very supportive. Staff told us that they enjoyed working at the practice and that they were a very good team. GPs also confirmed that there was an open and transparent culture of leadership and encouragement of team working. GPs we spoke with told us that team work at the practice was one of their greatest strengths.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the induction policy and bullying and harassment which were in place to support staff. Staff we spoke with knew where to find these policies if required.

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

St Katherine's Medical Practice was committed to continually improve their services by learning from and listening to their patients. The practice had a long standing Patient Participation Group (PPG) which was formed over 13 years ago. PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care. The purpose of the PPG was to discuss the services offered and discuss how improvements could be made to benefit the practice and its patients.

We met with five members of the PPG during our inspection. We also saw minutes of meetings where the group had discussed a range of topics. There was a dedicated page on the practice website for the group, as well as a direct email address for patient feedback. Minutes of the meetings, PPG reports and patient survey results were made available on the website and in reception. The PPG had also supported the practice with events such as patient education and annual flu clinics.

During 2014 members of the PPG and practice staff had reviewed and acted on a variety of feedback sources from patients, including the survey carried out in February 2014, patient complaints, verbal feedback gathered by PPG members and feedback on the NHS Friends and Family Test. The practice was disappointed with the results of the patient survey 2014, which showed the practice to be underperforming in eight areas. For example, only 66.93% of patients surveyed would recommend the practice. The practice had carried out investigations into the feedback

and concluded that the unfavourable results may have been due to the low response rates. The practice told us they felt that a sample size of 127 patients could not accurately reflect the services provided by the practice.

The PPG had helped the practice to analyse these results and established an action plan to improve the patient perspective of the practice and its staff. Patients were encouraged to complete a NHS Friends and Family questionnaire to obtain results to find out whether improvements had been made. Forms were made available to patients in the waiting room, consulting rooms and online. The results of the NHS Friends and Family Test in March 2015 found that feedback scores had improved and 95% of respondents stated they were either 'extremely likely' or 'likely' to recommend the practice to a friend or a member of their family.

Other actions to make further improvements included reception staff to commence a programme of training in customer care and providing patients with information to help them understand the appointments system. The practice also planned to improve the ways in which they communicated with patients. This included the development of a public relations campaign to tell patients about the practice and what they offered. This would be done in conjunction with the PPG. For example, an article had been added to the practice website and included in the practice newsletter to explain the appointment system and how patients could get the best from it.

The practice had gathered feedback from staff through informal staff meetings and discussions. Staff confirmed this. Minutes from meetings were kept and we were able to see evidence of a recent meeting between the practice manager and the GPs. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff confirmed that they worked well together as a team and felt well supported. They told us if they had any concerns they would follow the whistleblowing policy which was available to all staff on their computers in the practice. Staff confirmed that they knew who to talk with in the event they had any concerns.

Management lead through learning and improvement

The practice held regular meetings that ensured continued learning and improvements for all staff. We saw minutes of

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Good 

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staff meetings and management team meetings that showed discussions had taken place on a range of topics. This included significant events, complaints and palliative care for patients, with actions to be completed where appropriate.

The practice was able to evidence through discussion with the GPs and via documentation that there was a clear understanding among staff of safety and learning from incidents. Concerns, near misses, significant events and

complaints were appropriately logged, investigated and actioned. For example, we saw that significant event reporting had been discussed at the practice meeting held in February 2015.

Staff told us that the practice supported them to maintain their clinical professional development through training, clinical supervision and mentoring. Staff told us that the practice was very supportive with training and that regular protected time was provided for learning. Staff told us that information and learning was shared with all staff at practice meetings.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

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