Dr Forbes Watson

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Forbes Watson on 17 September 2015. Overall the practice is rated as good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- 100% of children aged five had received all immunisations required.
- All patients over the age of five received new patient health checks and patients over the age of five received health checks.
- The practice offered a private travel vaccination service and only charged patients for the cost of the vaccination. It did not add any practice costs or make any profit from travel vaccinations.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- More patients than average for the area and or nationally felt their GP was good at listening and gave them enough time ; patients had confidence and trust in the last GP they saw and said they were treated with care and concern.

Summary of findings

- An open access clinic was held every Friday at 4pm so that patients could be seen before the weekend and staff told us that patients who attended were always seen.

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

Importantly the provider should

- Ensure that the policies, procedures and risk assessment for the chaperoning of patients are clear and consistent.
- Document action taken as a result of infection control audits.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. Some actions, such as those taken as a result of infection control audits were not fully documented. The practice had comprehensive plans in place to ensure business continuity if there was an unforeseen event such as power failure.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the Clinical Commissioning Group area locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Practice staff knew patients well and used this to provide care and treatment that was tailored to meet individual patient's needs. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with local multidisciplinary teams to a provide care. Current QOF data indicated the practice had achieved 98.9% of the total number of points available which is higher than the national average of 94.2%.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Staff often worked with other local services, such as the local pharmacy to provide additional support to patients and monitor their wellbeing. A staff member also contacted patients by telephone to check on their progress and welfare if there had been a change to their circumstances, such as

Summary of findings

receiving new medication or being discharged from hospital. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with urgent appointments available the same day. An open access clinic was held every Friday at 4pm so that patients could be seen before the weekend and staff told us that patients who attended were always seen. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the GP and the practice manager. The practice had a number of policies and procedures to govern activity and held regular governance meetings but some policies and procedures were no longer in use and should be removed to prevent confusion and some did not have a documented review date . There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. All patients over the age of 75 had a named GP. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people and worked within established multi-disciplinary teams to improve outcomes for older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments were available to for patients with long-term conditions. The practice provided specialist nurse led care in asthma, diabetes, chronic obstructive pulmonary disease, cardiac care and strokes. Patients with more than two long term conditions had an admissions avoidance plan and staff worked within multi-disciplinary teams to provide care and assessments to patients with long-term conditions in their own home.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk and the practice worked within multi-disciplinary teams with health visitors and school nurses to improve outcomes for children at risk. Children who were unwell were prioritised and given appointments on the same day. Immunisation rates were very high for all standard childhood immunisations with immunisation rates for children under five being at 100%. Staff told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies.

Working age people (including those recently retired and students)

Good

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

Summary of findings

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, alerts were placed on patients records to identify those who were vulnerable and care plans were in place for the most vulnerable patients who were at risk of hospital admissions.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 93.33% of people experiencing poor mental health had a comprehensive, documented agreed care plan and 100% of patients with dementia had a face to face to face review in the last 12 months. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations and provided multi-disciplinary care with the consultant psychiatrist and community psychiatric nurse. It had a system in place to follow up patients and provided same day urgent access to patients who were experiencing poor mental health.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing above the local and national averages. There were 131responses and a response rate of 53.9%.

- 98.6% found it easy to get through to this surgery by phone compared with a CCG average of 85.3% and a national average of 74.4%.
- 94.5% found the receptionists at this surgery helpful compared with a CCG average of 89.8% and a national average of 86.9%.
- 84.2% with a preferred GP usually got to see or speak to that GP compared with a CCG average of 70.9% and a national average of 60.5%.
- 92.8% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 89.7% and a national average of 85.4%.
- 98% said the last appointment they got was convenient compared with a CCG average of 94.2% and a national average of 91.8%.
- 96.6% described their experience of making an appointment as good compared with a CCG average of 82.3% and a national average of 73.8%.
- 73.4% usually waited 15 minutes or less after their appointment time to be seen compared with a CCG average of 68.3% and a national average of 65.2%.
- 67.2% felt they didn't normally have to wait too long to be seen compared with a CCG average of 63.5% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received two comment cards which were positive about the standard of care received. On the day of our inspection we spoke to four patients and a member of the patient participation group. Patients told us that it was easy to get both routine and emergency appointments and commented that the service provided was tailored to meet their individual needs.

We reviewed results from the friends and family tests for the period December 2014 to August 2015. 68 patients responded to the survey and all of the patients indicated that they would be extremely likely to recommend the practice to their friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that the policies, procedures and risk assessment for the chaperoning of patients are clear and consistent.
- Document action taken as a result of infection control audits.

Dr Forbes Watson

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a **CQC Lead Inspector.** The team included a GP specialist adviser and a second CQC inspector.

Background to Dr Forbes Watson

The practice is located in a converted hotel close to the centre of Lyme Regis and the premises are shared with a dental practice. The premises are owned by the GP and the practice has three consulting rooms and two treatment rooms. The practice provides care and treatment to 2077 patients and 51.6% of the patient population are over the age of 65. The practice also provides care to a large number of temporary residents, especially during the summer months due to the influx of holiday makers to the town.

The practice has one full-time male GP and a part-time female GP. The practice is a training practice and has a Foundation doctor level 2 which is a qualified doctor who is undertaking further medical training programme to become a GP. Other staff include two nurses, a practice manager, reception and administration staff.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8.30am 10.30am every morning and 3pm and 5pm on Monday and Tuesday, 3.30pm and 5.30pm on Thursdays and there is an open access clinic at 4pm on a Friday. Extended hours surgeries are offered until 7pm on a Monday and between 8.30am and 9.30am one Saturday each month.

GPs have opted out of providing their own out of hours care and care is provided by Dorset Ambulance Service as part of the 111 service.

The practice has a personal medical services (PMS) contract, which is a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract.

The practice is registered to provide the regulated activities of surgical procedures, diagnostic and screening procedures, maternity and midwifery services, family planning and treatment of disease, disorder or injury at one location.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme to identify whether the practice meets the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. We carried out an announced visit on 17 September 2015. During our visit we spoke with a range of staff including GPs, nurses, the practice manager, administration and reception staff and spoke with four patients who used the service. We observed how people

Detailed findings

were being cared for and reviewed the personal care or treatment records of patients. We reviewed two comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. People affected by significant events received a timely response with an apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system. All complaints received by the practice were automatically treated as a significant event. The practice carried out an analysis of the significant events.

We reviewed eight significant events that had been recorded by the practice in the last 12 months and saw that the practice had carried out an analysis of the significant events and shared learning from their outcomes. For example, a significant event had been reported where a GP had visited a patient at a care home and been told that they had not received their prescription. This was investigated and learning regarding the management of prescriptions was shared at the next practice meeting and minutes of this meeting were available to confirm this.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies, including a whistleblowing policy were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings and we reviewed minutes of a risk meeting held at the practice on 12 June 2015 which included a social worker, GP, district nurse, palliative care nurse and practice nurse. The meeting was convened to discuss the care and welfare of vulnerable patients. There was a system in place to link childrens records with their parents records to identify children who may be vulnerable due to their parents health needs. Staff demonstrated they understood their safeguarding responsibilities and we were given an example of how practice staff had responded to information from the safeguarding team to follow up on the care of a potentially vulnerable child. All GPs had completed training to level three in safeguarding children and training in safeguarding vulnerable adults and all other staff had received training relevant to their role.
- A notice was displayed in the waiting room, advising patients that staff would act as chaperones. All clinical staff that acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However the practice policy indicated that non-clinical staff may act as chaperones. The practice had conducted a risk assessment regarding the requirement for DBS checks and this indicated that reception staff did not require a DBS as they did not perform chaperone duties. The risk assessment should be updated to reflect the procedures for non-clinical staff who do not have a DBS check.
- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety poster available in the staff office and other posters included guidance on moving and handling and first aid. The practice had a fire management policy which was reviewed in September 2015 and staff were trained to act as fire wardens. An external fire risk assessment had been completed in November 2012 and contained an action plan. Actions had been completed and the risk assessment had been updated in March 2015 to reflect the actions taken. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. Portable appliance testing was completed on 15 September 2015. The practice also had a variety of other risk assessments in place to monitor safety of the premises including a risk assessment of the premises that had been reviewed and updated in March 2015. There was a

legionella risk assessment in place dated 29 July 2015 that had been completed by an external company. The assessment made five recommendations an including the cleaning and disinfecting of tanks. We saw that, where appropriate these actions had been scheduled for completion by the external company and where the practice had been required to take action, these actions had been completed.

- Systems were in place to ensure that staff received alerts from the Medicines and Health Products Regulatory Agency (MHRA) and staff recorded action taken as a result of alerts received. There was a policy on the management of MHRA alerts. For example, we saw that an alert had been received to identify that a type of glucose monitor should no longer be used. Staff recorded that they had checked patient records to identify which patients were using the monitor, contacted the patients and replaced those monitors that were in use.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams and attended meetings to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Infection control audits were completed every three months and actions had been taken as a result of the audits. We discussed with the infection control lead that one of the couches in the consultation room had a small rip and they identified that this was used for consultations only and not for clinical procedures .The action taken as a result of infection control audits was not documented as an action plan but we were shown evidence that action had been taken to rectify shortfalls. The practice had systems in place to manage healthcare waste and we saw that a healthcare waste audit had been completed by an external organisation the day prior to our visit. The report identified areas that the practice needed to address including updating procedures for the disposal of inner blister packs from medicines and aerosols. The practice was cleaned by contracted staff that followed a schedule of cleaning. The standard of cleaning was checked on a daily basis and practice staff used a book to record discussion with contract cleaning staff and action taken as a result.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Controlled drugs were appropriately stored and there were procedures in place for the destruction of controlled drugs by the pharmacy team from the clinical commissioning group (CCG). A nurse practitioner was responsible for managing prescribing alerts and these were cascaded to staff and patients records were reviewed to see if any action should be taken. Nurses provided vaccinations using Patient Group Directions, which are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. A healthcare assistant was previously employed and had provided influenza vaccinations using Patient Specific Directions which are written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- Regular medication audits were carried out with the support of the local CCG pharmacy teams to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. The practice prescribing rate for some non-steroidal anti-inflammatory medicines was significantly lower than the national average. This could mean that GPs were prescribing other medications that had more side effects. GPs told us that the low numbers had been reviewed and they had three patients taking alternative medications and the side effects had been discussed with them. A nurse told us that when patients were prescribed new medicines they would go through the side effects with the patients and then contact them after 48 hours to see how they were responding to the medication and whether they were experiencing any side effects.
- Recruitment checks were carried out and the two files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. GPs had been revalidated or were in the process of being revalidated. (Every GP is appraised annually, and undertakes fuller

Good

Are services safe?

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

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice had a policy regarding the staffing levels and this was supported by a risk assessment, which had been updated. This risk assessment was relevant to the practice in part but also included some information about staffing groups that were not available at the practice. There was a system in place for all the different staffing groups to ensure that enough staff were on duty and the practice had arrangements in place with a local practice to provide cover when the practice was closed.

Arrangements to deal with emergencies and major incidents

There was an alarm which alerted staff to any emergency. All staff received annual basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. A policy on the management of first aid was available and some generic guidance on the provision of first aid was available to staff. First aid was provided by the duty GP and the practice nurse. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan and recovery plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. We saw that two significant events had been reported, where staff had invoked the business continuity plan. For example, the practice had a power failure and the business continuity plan had been used to provide guidance to manage this event.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. We saw that NICE guidelines were an agenda item at practice meetings and updated guidance had been discussed at a practice meeting on 31 August 2015. The practice used guidelines from NICE to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were followed through audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Current results were 98.9% of the total number of points available which is higher than the national average of 94.2%. This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013 to 2014 showed;

- Performance for diabetes related indicators was better than the national average. For example, the percentage of patients with diabetes, on the register, who had a record of an albumin: creatinine ratio test, used to identify kidney disease that can occur as a complication of diabetes was 95.06% compared to the national average of 85.94%.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average. For example, the percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding nine months is 150/90mmHg or less was 90% compared to the national average of 83.11%.
- Performance for mental health related indicators was better than the national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder, and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 93.33% compared to the national average of 86.04%.
- The percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 100% compared to the national average of 83.82%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. There had been five clinical audits completed in the last two years where the improvements made were implemented and monitored. We reviewed a medicines reconciliation audit and an audit of medication reviews for patients who were over the age of 65 and were being prescribed ten or more repeat medications. An audit of patients records to identify those patients who had a record of their requirements regarding resuscitation recorded led to increased discussion with patients about their end of life wishes and improved recording around do not resuscitate.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. Most staff had been employed at the practice for at least ten years and the practice provided continuity of staff. The practice rarely used locums and staff worked together to cover each others absences.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality. A staff handbook was available to staff on the practice computer system.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate face to face and on line training to meet their needs and were supported to under further training as part of their development. For example, a nurse had undertaken diplomas in long term conditions and minor illnesses. Staff had ongoing support through internal and external meetings, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors and nurses. All staff had had an appraisal within the last 12 months.

Good

Are services effective?

(for example, treatment is effective)

- The practice had a training matrix that was used to identify when training needed to be updated. We reviewed the training matrix and identified that staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way and the practice had established and continuous links with other service providers in the local community, such as community nurses, safeguarding teams and a community psychiatric nurse.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a quarterly basis and that care plans were routinely reviewed and updated. We reviewed minutes of a virtual ward patient meeting dated 7 August 2015. The meeting had been attended by an occupational therapist, community midwife, health and social care coordinator, social worker and community psychiatric nurse. The meeting discussed the care of vulnerable patients and provided updates on their conditions. We saw that some patients had also been discussed at a previous meeting on 24 July 2015 and their care was being monitored over time.

We reviewed a significant event where the practice had urgently referred a patient to other organisations and taken steps to manage the safety and wellbeing of the patient until they could be supported by the relevant services.

The practice worked closely with the local pharmacy and staff told us that the pharmacy rang the practice if a patient presented that they felt needed to be seen by a GP or if patients had not responded to medication deliveries or if they were concerned about a patient. The practice arranged for either a district nurse or a GP to visit the patient. The practice contacted the pharmacy for a patient admitted to hospital who had not needed their medication.

The practice had policies and procedures regarding data protection and access to medical records that had been reviewed in September 2015.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. The practice had policies and procedures regarding consent, including a policy on the use of the Mental Capacity Act 2005 and these had been reviewed in August 2015. Policies included forms to obtain consent for minor surgical procedures such as wart removal. Staff had received training in the Mental Capacity Act and staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear the GP or nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment. A staff member told us that they worked with a local Independent Mental Capacity Adviser when required and would place an alert on the patients' record if the patients' capacity to consent was impaired. The process for seeking consent was monitored through records audits to ensure it met the practices responsibilities within legislation and followed relevant national guidance.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and patients over the age of 75 who required support to live at home independently. Patients were then signposted to the relevant services and posters were available to inform patients how to access local groups, such as mental health services . Patients who may be in need of extra support were identified by the practice and as this was a small local community, staff would telephone patients to follow up on their care and check that their condition had not deteriorated. This

Good

Are services effective?

(for example, treatment is effective)

included vulnerable patients with minor ailments and those with long term conditions. The practice had provided health promotion events to patients on areas such as smoking cessation, sun and skin cancer awareness and awareness about support available to carers.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 81.25%, which was comparable to the national average of 81.88% There was a policy to recall patients for routine cervical screening test. The practice also encouraged its patients to attend for screening and reviews that were not related to QOF targets such as thyroid testing.

Childhood immunisation rates for the vaccinations given were predominantly higher than the national average. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 83.3% to 100% and immunisation rates for five year olds were all at 100%. Flu vaccination rates for the over 65s were 75.47%, and at risk groups 54.01%. These were also above national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Routine checks were available for all patients over the age of five and for patients over the age of 75. A staff member told us that health checks for patients under the age of five were conducted by health visitors. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone and that people were treated with dignity and respect. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. However patient feedback indicated that conversations in the waiting room could be overheard by other patients. We did not overhear any private conversations during our observations. The practice had put a sign in the waiting room asking patients to stand back from the desk and respect the privacy of other patients. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Both of the patient CQC comment cards we received were positive about the service experienced. Patients that we spoke to said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. We also spoke with a members of the patient participation group (PPG) on the day of our inspection. They also told us they were highly satisfied with the care provided by the practice and said their dignity and privacy was respected. Patients told us that staff provided a personal and tailored services, responding to their individual needs.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was predominantly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96.7% said the GP was good at listening to them compared to the CCG average of 91.9% and national average of 88.6%.
- 95.1% said the GP gave them enough time compared to the CCG average of 89.9% and national average of 86.8%.
- 97.7% said they had confidence and trust in the last GP they saw compared to the CCG average of 96.9% and national average of 95.3%
- 96.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89.2% and national average of 85.1%.
- 91.5% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92.3% and national average of 90.4%.
- 94.5% patients said they found the receptionists at the practice helpful compared to the CCG average of 89.8% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patients' health issues were discussed with them and they felt involved in decision making about the care and treatment they received. Patients were supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback we received was also positive and aligned with these views. Staff told us that they enjoyed working in a small practice; they knew their patients and could provide additional support to meet their needs.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and results were in line with local and national averages. For example:

- 93.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89.1% and national average of 86.3%.
- 87.3% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86.1% and national average of 81.5%.
- 91.1% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 91.7% and national average of 89.7%.
- 86.3% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 87.4% and national average of 84.9%.

There were no signs in the reception area offering translation services to patients. Staff told us that they had

Good

Are services caring?

one patient who did not have English as a first language and this patient was always accompanied by a relative but that if a patient did require a translation service they would use a computer based system which they could access.

Patient and carer support to cope emotionally with care and treatment

A patient information pack was available and explained how to access the services provided by the practice, for example, emergency contraception, repeat prescriptions and test results. Notices in the patient waiting room told patients how to access a number of support groups and organisations. We saw that staff cared for their patients. For example, an older patient had failed to attend for an appointment and staff followed this up to check on their welfare and arranged to see them later that day.

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all people who were carers and 20.6% of the practice list had been identified as carers and were being supported by the named carers lead. for example, by referral for social services support. The practice worked closely with other agencies such as palliative care nurses and district nurses to support patients who were carers.

Staff told us that if families had suffered bereavement, the GP contacted them or visited them. They were offered support or advice on how to find a support service. There was no information in the reception area to signpost patients to bereavement services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. A GP was the chair for the CCG and GPs attended meetings. The practice provided a directed enhanced service for childhood vaccinations and immunisations and immunisation rates for children rates for children under two were in line or higher than national averages and immunisation rates for children under five were all 100%.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;.

- The practice provided services such as blood testing and deep vein thrombosis care on site to avoid patients having to travel to the local hospital.
- Home visits were available for older patients / patients who would benefit from these.
- Urgent access appointments were available for children and those with serious medical conditions.
- All new patients over the age of five years had a new patient health check and health checks were completed on patients over the age of 40.
- The practice offered travel vaccinations to patients and only charged them for the cost of the vaccination and the practice did not make any profit from travel vaccinations.
- The practice provided support to people experiencing poor mental health and worked with local a psychiatrist to improve outcomes for patients. It signposted patients experiencing poor mental health to support organisations such as steps to wellbeing.
- The practice provided support to patients who were vulnerable and worked with a multi-disciplinary team that included community services, a social worker, occupational health, health visitor and school nurses. The multi-disciplinary team was well established and had worked together for almost twenty years.
- The practice worked with a multi-disciplinary team to avoid hospital admissions for older people. Virtual ward meetings were held every three weeks and GPs had quarterly face to face meetings with six separate care homes in the area to review the care of patients. We saw minutes of a risk meeting held at the practice on 12 June 2015 which discussed how care could be provided to patients who were at risk of admissions and needed reablement support. Intermediate care beds were available at a local care home and the multi-disciplinary team supported the patient's rehabilitation. The practice used a board in a staff only area to record patients who were at risk of hospital admission or who had been admitted into hospital. Patients who were admitted or discharged from hospital had their care followed up within 24 hours of the practice being made aware.
- The practice worked with a substance misuse service to provide support to patients.
- The practice was accessible to patients in wheelchairs and those with pushchairs. Accessible toilet facilities and a baby changing facilities were available. The practice did not have a hearing loop. Staff told us that they know their patients and can speak louder to patients if their hearing is impaired but we discussed that it would be beneficial to add a hearing loop.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Appointments were from 8.30am 10.30am every morning and 3pm and 5pm on Monday and Tuesday, 3.30pm and 5.30pm on Thursdays and there was an open access clinic at 4pm on a Friday. Extended hours surgeries are offered until 7pm on a Monday and between 8.30am and 9.30am one Saturday each month. Patients told us that staff were helpful and they would be seen on the same day if they felt their need was urgent, even if they came to the surgery to wait to be seen in between scheduled consultations. The practice had an arrangement with another local practice that provided emergency cover on a Wednesday afternoon when the practice was closed.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was higher than local and national averages and people we spoke to on the day were able to get appointments when they needed them. For example:

- 88.3% of patients were satisfied with the practice's opening hours compared to the CCG average of 78.8% and national average of 75.7%.
- 98.6% of patients said they could get through easily to the surgery by phone compared to the CCG average of 85.3% and national average of 74.4%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 96.6% of patients described their experience of making an appointment as good compared to the CCG average of 82.3% and national average of 73.8%.
- 73.4% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68.3% and national average of 65.2%.

The practice had completed their own patient satisfaction survey and provided an action plan that they had completed in order to respond to information received. This included putting privacy signs in reception and advertising the online appointment booking services. The practice issued a newsletter to patients which identified changes to the service. The Autumn 2015 newsletter provided information to patients about how to register for on line prescriptions and information about immunisations and changes to staff.

Listening and learning from concerns and complaints

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

We saw that information to help patients understand the complaints system was available in the waiting room.

We looked at two complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency dealing with the complaint. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we reviewed a complaint and saw that the patient had been given a timely apology and that learning from the complaint had been discussed with staff. The action taken was record in the complaints record. There was no individual record of all complaints raised in order for staff to complete trends analysis on complaints more easily but we were told that each complaint was reviewed against other individual complaint records to ensure that it was not part of a trend.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide high quality service delivery, coupled with a friendly, reassuring and accountable culture. The practice identified that in formulating the vision they had drawn on the views and experience of patients. The practice identified an aim was to enhance the quality of life of its patients and their carers. The vision and aims were underpinned by a series of documented values. There was no formal business plan in place but the provider was an individual and therefore did not hold formal business meetings. The practice manager received business support from an external company.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities
- Practice specific policies were implemented and were available to all staff. We saw that the policy folder had been updated and these updates had been shared with staff, who had signed to say that they had read the updates.
- A comprehensive understanding of the performance of the practice.
- A programme of continuous clinical and internal audit which is used to monitor quality and to make improvements
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions

Leadership, openness and transparency

The provider of the service had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The GP was visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. The responsible GP and the practice manager worked together to encourage a culture of openness and honesty.

Staff told us that regular team meetings were held. Clinical meetings were held every three months and practice meetings were also held every three months. All staff met for an informal meeting every Friday morning and GPs met for an informal discussion every Tuesday evening. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. We also noted that team away days were held every month. Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, proactively gaining patients' feedback and engaging patients in the delivery of the service. It had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was a small PPG which met on a regular basis, and submitted proposals for improvements to the practice management team. For example, a member of the PPG told us that they had raised the fact that the entrance to the practice was not completely level due a small step at the doorway and this step had been removed and made level. We spoke to a member of the patient participation group and we were told that the practice had a meeting last week and the practice had responded to the feedback received from the patient participation group and that patients could always contact the practice manager to discuss any concerns. We were told that in the past the practice had responded to feedback from patients by expanding the parking at the practice and had removed the radio after patients complained that it was too noisy. They now used a television in the waiting room, which was on low but was helped to distract patients waiting from conversations between reception staff and patients.

The practice had a suggestions box to obtain feedback from patients but staff told us that in small town patients will feedback with staff as they meet them.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any

Are services well-led?

Good

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

concerns or issues with colleagues and management. They told us that they could contact the GP if they had concerns, even if they were not on the premises and would not hesitate to do so. Staff told us they felt involved and engaged to improve how the practice was run.