Dr Richard Hirson

Quality Report

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Date of inspection visit: 14 July 2015
Date of publication: 27/08/2015

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 carried out an announced comprehensive inspection at Manea Surgery on 14 July 2015. The overall rating for this practice is good. We found the practice to be good for providing safe, effective, caring, responsive and well-led services. The quality of care experienced by older people, by people with long term conditions and by families, children and young people is good. Working age people, those in vulnerable circumstances and people experiencing poor mental health also receive good quality care. Our key findings across all the areas we inspected were as follows:

- The practice was a friendly, caring and responsive practice that addressed patients' needs and that worked in partnership with other health and social care services to deliver individualised care.
- The premises were clean and tidy.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Patients had their needs assessed in line with current guidance and the practice had a holistic approach to patient care. The practice promoted health education to empower patients to live healthier lives.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice had good facilities and was well equipped to treat patients and meet their needs. Where the practice had highlighted the need for improvement of the premises an action plan had been implemented.
- The staff worked well together as a team.

We saw one area of area of outstanding practice:

- The lead GP actively engaged with the local community which had led to the implementation of several community initiatives such as walking groups, bowling groups and social gatherings. The lead GP also provided anticipatory home visits to older

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patients in the community and provided us with examples where they had organised community events and combined these with vaccination or health check awareness for patients.

However there was one area of practice where the provider needs to make improvements. Importantly the provider should:

- Improve the arrangements for undertaking appraisals of staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing patients' mental capacity and promoting good health. Staff had received training appropriate to their roles but a small number of staff had some mandatory training overdue. Further training needs had been identified and appropriate training planned to meet these needs. There was a lack of evidence around appraisals for seven members of staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for most aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. 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 a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

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 well to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the vision surrounding good patient care and their responsibilities in relation to this. There was a clear leadership structure and most staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. Staff had received inductions and attended weekly staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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 in its population and had a range of enhanced services, for example, in dementia and end of life care.

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The lead GP had long standing patient knowledge allowing for recognition of changing needs in this patient group, for example increasing frailty and loneliness. This had led to the implementation of several community initiatives such as walking groups, bowling groups and social gatherings.

The lead GP provided anticipatory visits to older patients in the community.

People with long term conditions

Good

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

Repeat prescriptions provided explanations around medication, stating its purpose and why it was prescribed.

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, for example, children and young people on the safeguarding register. Immunisation rates were generally above local averages for standard childhood immunisations. Patients 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.

Summary of findings

The practice ran occasional vaccination clinics with the addition of family fun elements, such as bouncy castles.

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 offered late appointments one day a week and a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances might make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. The practice provided a flexible approach to consultations for these patients.

Performance for palliative care related 2013-2014 QOF indicators was higher at 100% than the local average of 99.5%.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had advised vulnerable patients about how to access various support groups and voluntary organisations.

The lead GP had extensive experience of working with drug users due to previous roles and applied the experience in the treatment of addictive drug users by providing easy access and supervised dispensing. 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). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It had carried out advance care planning and clinical audits for patients with dementia. The practice kept a

register of patients with mental health illness which comprised of 12 patients, of which eight were considered to have severe mental health illness. Of these eight, seven had comprehensive care plans in place.

The practice had advised patients experiencing poor mental health about how to access various support groups and voluntary organisations, including access to a community psychiatric nurse and counselling services. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Prior to our inspection we arranged for a comment box to be left at the practice for patients to provide us with written feedback on their experience and views about the service provided. We collected 20 comment cards; all of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. Most cards contained comments around the high level of care patients felt they received from the GPs as well as the health care assistants. We spoke with three patients during our inspection, including one member from the patient participation group (PPG). The PPG is a group of patients registered with the practice who have no medical training, but have an interest in the services provided. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. The patients we spoke with told us that they felt the practice was clean. They reported that the practice provided a very good personal service and that all staff delivered good clinical care and referrals. The comment cards reflected these views, all with very positive comments. Patients we spoke with confirmed that they could always get an urgent appointment with a GP on the day.

Areas for improvement

Action the service SHOULD take to improve

- Improve the arrangements for undertaking appraisals of staff.

Outstanding practice

- The lead GP actively engaged with the local community which had led to the implementation of several community initiatives such as walking groups, bowling groups and social gatherings. The lead GP also provided anticipatory home visits to older patients in the community and provided us with examples where they had organised community events and combined these with vaccination or health check awareness for patients.

Dr Richard Hirson

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC lead inspector and included a GP specialist advisor and a practice manager specialist advisor.

Background to Dr Richard Hirson

Manea Surgery in Manea, Cambridgeshire provides services mainly to patients living in Manea and the surrounding area. The practice is managed by an individual GP. The practice also employs one part-time salaried GP. There is one nurse and there are two healthcare assistants active in the practice. The clinical team is supported by a team of administration and dispensing staff. The practice has a dispensary lead by a dispensary manager. The practice has a patient population of approximately 2100. The practice is open every weekday between 08:30 and 17:30. Extended hours are provided on Tuesday evenings until 19:45. The practice website clearly details how patients may obtain services out-of-hours.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme in accordance with 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

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)

Before visiting, we reviewed a range of information that we held about the practice and asked other organisations to share what they knew. During our inspection on 14 July 2015 we spoke with a range of staff including the lead GP, practice nurse, dispensary, reception and administrative staff. We observed how people were being cared for and

Detailed findings

reviewed the personal care or treatment records of patients. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

Good

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. Reported incidents and National Patient Safety Alerts were used as well as comments and complaints received from patients to collate risk information. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses.

We reviewed 12 months of safety records and incident reports. These showed that the practice had managed risk and patient safety consistently over this period and could show evidence of a safe track record. Learning and changes from incidents had taken place, for example focused learning on iron deficiency in pregnancy.

The practice had policies and procedures for reporting and responding to accidents, incidents and near misses. Staff we spoke with told us that they were aware of the procedures for reporting and dealing with risks to patients and concerns.

We saw a daily log that contained relevant information, which proved useful for part time staff. We were also told of discussions with the staff where information was shared to improve patient safety. Staff told us that managers communicated with them regularly.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The practice kept records of significant events that had occurred and these were made available to us. Significant events and the actions resulting from them was documented in individual event records as well as a summary. Six events were captured on the summary. We reviewed these incidents and found they had been investigated and responded to appropriately.

National patient safety alerts were disseminated electronically to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had safeguarding vulnerable adults and children policies in place which were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare.

The practice had a dedicated GP appointed as lead in safeguarding and they had received the appropriate level of training. All staff we spoke with were aware who this lead was and who to speak to both internally and externally if they had a safeguarding concern. The practice held monthly multi-disciplinary meetings during which safeguarding of patients was discussed. Staff, except two part-time receptionists and two health care assistants, had received up-to-date safeguarding children training at a level suitable to their role for child safeguarding, For example the lead GP had undertaken level three training. Except for the health care assistants and three receptionists, staff had also received safeguarding vulnerable adults training and understood their role in reporting any safeguarding incidents. Further safeguarding and Mental Capacity Act training was arranged for October 2015 in collaboration with another local practice to ensure all staff were up to date.

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 subject to child protection plans and vulnerable adults. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services. GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. A chaperone policy was available on the practice's computer system. The practice nurse and reception staff acted as chaperones if required and a notice was in the waiting room to advise both male and female patients the service was available should they need it. Staff had received a Disclosure and Barring Service (DBS) check.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Records

showed fridge temperature checks were carried out twice a day which ensured medication was stored at the appropriate temperature. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice offered a choice of methods (including on-line and via paper repeat requests) for patients to order repeat prescriptions. A prescription ordering and delivery service was offered to housebound patients in rural areas. The practice provided disposable medication dispensers for 29 patients every seven days; an internal protocol to produce these was in place.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs; we were shown an audit dated April 2015. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area. Standard procedures were in place that set out how they were managed. These were being followed by the practice staff. There were arrangements in place for the destruction of controlled drugs.

The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff told us, and records showed that they had completed training appropriate to their role and kept up to date through external courses and in-house events. We saw a positive culture in the dispensary for reporting and learning from medicines incidents and errors. Incidents and near misses were logged and reviewed as significant events. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

All areas within the practice were found to be clean and tidy. Comments we received from patients indicated that they found the practice to be clean.

The practice nurse was the designated clinical lead for infection control but had not received additional infection control lead training. This role was to be taken over by a health care assistant in the weeks following our inspection who, we were told, would be appropriately trained. There was an infection control policy in place, including a needle stick injury protocol.

There were clear, agreed and available cleaning routines in place for the cleaning of the practice. We saw that cleaning materials were stored safely. We saw there were systems for the handling, disposal and storage of clinical waste in line with current legislation. This ensured the risk of cross contamination was kept to a minimum.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid soap, hand gel and paper towel dispensers were available in treatment rooms. We saw records to confirm that patient privacy curtains were changed on a regular basis. The practice used only single use instruments for all minor surgery or other interventions they performed for which it had a policy in place.

Personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We found that the practice had sufficient stocks of equipment and single-use items. Staff told us that all equipment was tested and maintained regularly and we saw equipment maintenance records that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the next testing date. We saw evidence of up-to-date calibration of relevant equipment.

Good

Are services safe?

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We saw that clinical staff had up to date registration with the appropriate professional body. We were shown evidence of current Disclosure and Barring Service (DBS) checks for all relevant staff.

The practice had gone through various changes with staffing over the previous six months including the departure of a GP partner and nurse practitioner. This had developed into greater reliance on the role of the health care assistants in the practice.

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment for all but some inconsistency was noted around completed cv's in staff files.

Staff told us about the arrangements for planning and monitoring the number and mix of staff needed to meet patients' needs. Staff told us there was enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. There were three members of staff who were qualified to work in both the dispensary and reception which increased the ability to cross over between departments and cover each other's roles.

Monitoring safety and responding to risk

The lead GP was responsible for the compliance with fire, legionella and other health and safety regulations for the premises. We saw an up-to-date fire risk assessment, and health and safety information was displayed for staff. A legionella risk assessment was undertaken by an external company with no further actions required.

There were procedures in place for monitoring and managing risks to patient safety. The practice had policies and procedures in place for recognising and responding to risks. Staff we spoke with told us that they were aware of these procedures. Staff were able to demonstrate the correct action to take if they recognised risks to patients; for example they described how they would treat and escalate concerns about adults or children or a patient who was experiencing a physical or mental health condition or crisis.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Medical equipment including an Automated External Defibrillator (AED, a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm) and oxygen were available for use in the event of a medical emergency. The equipment was checked regularly to ensure it was in working condition. Records indicated that all staff (clinical and non-clinical) were up-to-date with training for basic life support.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included medicines for the treatment of cardiac arrest and anaphylaxis (a sudden allergic reaction that can result in rapid collapse and death if not treated). Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use, we saw evidence of this.

A business continuity plan was in place to deal with a range of emergencies that might impact on the daily operation of the practice. Each risk was detailed and mitigating actions recorded to reduce and manage the risk. Risks identified included loss of utilities and loss of access to paper medical records. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. A copy was held off site.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and staff we spoke with could clearly outline the rationale for their approaches to treatment. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. 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. NICE is the organisation responsible for promoting clinical excellence and cost-effectiveness and producing and issuing clinical guidelines to ensure that every NHS patient has fair access to quality treatment.

The practice used computerised tools to identify patients with complex needs who had a named GP and multidisciplinary care plans documented in their case notes. The practice used a system of coding and alerts within the clinical record system to ensure that patients with specific needs were highlighted to staff on opening the clinical record. For example, patients on the 'at risk' register, learning disabilities and palliative care register. We were shown the process the practice used to review patients recently discharged from hospital. Patients were assessed individually according to the risks they presented with and changes made as appropriate to their care plans.

Where appropriate, for example for palliative care patients, patient outcomes were coordinated with multidisciplinary reviews to deliver the most appropriate care.

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

Management, monitoring and improving outcomes for people

The practice showed us two clinical audits that had been undertaken in the last two years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit done on antipsychotic prescribing in dementia had led to a regular review during which medication would be reviewed for all patients with dementia. The other example included an audit around antibiotic prescribing. GPs maintained records showing how they had evaluated the audits and documented the success of any changes. Following clinical audit cycles we saw that the outcomes had been discussed, shared and agreed at clinical meetings and the practice was able to demonstrate the learning and changes following the initial audit. The practice also used the information collected for the quality and outcomes framework (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures) and performance against national screening programmes to monitor outcomes for patients. The practice achieved 86.7% of the total QOF target in 2013-2014, which was below the national average of 93.5%. Specific examples of the practice's QOF included:

- Performance for asthma related indicators was better at 100% than the national average of 97.2%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months was higher at 100% than the national average of 83.8%.
- Performance for mental health related QOF indicators was lower at 83% than the national average of 90.4%.
- Performance for palliative care related QOF indicators was better at 100% than the national average of 96.7%.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. For example, we saw that the practice had a register of patients with a learning disability, mental health condition and a register of vulnerable adults. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review. At the time of our inspection the practice had 14 patients on the learning disability register, all of which had received a health check during 2014-2015 and in the year to the date of our inspection four patients had received a health check. On the mental health register of the practice were 12 patients, of which eight were considered to have a severe mental health illness. Of these eight, seven had comprehensive care plans in place. The GP demonstrated awareness of the specific needs of patients and how they supported their individual needs.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed

Good

Are services effective?

(for example, treatment is effective)

by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the staff were prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The practice had implemented systems for managing patients with palliative care needs who were nearing the end of their lives. The practice had a palliative care register and together with other healthcare professionals, and the patient and their relatives, met regularly to discuss each individual to tailor a care plan to meet their needs.

Effective staffing

Practice staffing included medical, nursing, dispensary and administrative staff. We reviewed training records and saw that staff were up to date with most mandatory training; the practice had identified the need for MCA training for staff and this was planned for October 2015.

All GPs were up to date with their annual 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).

Some staff undertook annual appraisals that identified their learning needs and from which action plans were documented. However, there was a lack of evidence around appraisals for seven members of staff, some had received recent appraisals but no outcomes were recorded and some had not had any recent appraisals. The lead GP highlighted this to us at the beginning of the inspection, stating awareness and the intention to address this in the near future as a matter of urgency.

Reception and dispensary staff had undergone training relevant to their role. Staff described feeling well supported to develop further within their roles. The practice had an induction programme for newly appointed members of staff that covered such topics as fire safety, health and safety and confidentiality. The practice did not have a complete staff handbook in place but acknowledged this on the day and were updating it to ensure it was in place for staff.

Working with colleagues and other services

The practice worked with other services to meet patients' needs and manage complex cases, for example we saw evidence of referrals to district nurses for matters such as application of dressings. There were clear procedures for receiving and managing written and electronic communications in relation to patients' care and treatment. Correspondence including test and X ray results, letters including hospital admissions and discharges, out of hour's providers and the 111 summaries were reviewed and addressed on the day they were received by the GPs. We spoke with a member of the district nursing team on the day of our inspection who confirmed cooperation between the practice and the district nurses was good and support from the GP was appropriate. During this discussion the GP was commended on his patient population knowledge and it was confirmed that communication between the practice and the district nursing team was two-way, with both sides listening to the other. The practice held monthly multidisciplinary (MDT) team meetings to discuss the complex needs of patients. These meetings were attended by community services such as district nurses and palliative care nurses. Staff felt this system worked well but remarked that not all services attended regularly despite being invited. Decisions about care planning were documented in a shared care record, maintained by a MDT coordinator.

There was an effective system for managing results and discharge summaries and updating patient records and repeat medicines. The practice provided rooms for visiting services to improve access for patients. For example, health visitors and counselling services.

Information sharing

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

Good

Are services effective?

(for example, treatment is effective)

manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

The practice had a policy in place to help GPs with determining the mental capacity of patients. We spoke with the GP about their understanding of the Mental Capacity Act 2005 and Gillick guidelines. The lead GP was aware of Gillick guidelines for children. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge.

All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. The practice had been proactive in organising further training on the Mental Capacity Act 2005 which was planned for October 2015. Staff were aware of the different types of consent, including implied, verbal and written. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it). 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.

Health promotion and prevention

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice had proactively contributed to better care and admission avoidance for older patients in the community. The lead GP explained that the long standing patient knowledge they had allowed for recognition of changing needs in this patient group, for example increasing frailty and loneliness. This had led to the implementation of several community initiatives such as walking groups, bowling groups and social gatherings. The lead GP also provided anticipatory visits to older patients in the community. The lead GP had extensive experience of working with drug users due to previous roles and applied the experience in the treatment of addictive drug users by providing easy access and supervised dispensing.

The practice used chronic disease management clinics to promote healthy living and health prevention in relation to the patient's condition. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was overall above average for the majority of immunisations where comparative data was available. For example:

- The flu vaccination rate for the over 65s was 53.4%, which was above the national average of 52.3%.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 72.7% to 95.5% and five year olds from 89.3% to 100%. The latter were above local averages.

Up to date information on a range of topics and health promotion literature was readily available to patients at the practice. This included information about support services, such as carer support.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the National GP Patient survey published in July 2015, where 287 surveys had been sent to patients, with a 39% response rate. The evidence from these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. Results showed the practice scored 97% for patients who rated the practice as good in comparison to the national average of 85%. The practice was above average for its satisfaction scores on consultations with doctors and nurses, with 95% (compared to 89% nationally) of practice respondents saying the GP was good at listening to them, 99% (compared to 91% nationally) saying the nurse was good at listening to them, 98% (compared to 87% nationally) saying the GP gave them enough time and with 99% (against 92% nationally) saying the nurse gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We collected 20 comment cards. All of these cards indicated that patients were very satisfied with the support, care and treatment they received from the practice. We also spoke with patients on the day of our inspection. All the patients we spoke with told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / 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. The practice's switchboard was located near the reception desk, but staff were aware of the need for confidentiality and always attempted to keep information private. Patients commented that confidentiality could be an issue at the front desk when queuing. The practice acknowledged this and informed us a private room to discuss matters would always be available if requested. To avoid these problems in the future the practice was due to undergo building work. The work was planned to amend the queuing area so that confidentiality for patients at the reception desk was maintained. We saw evidence of the planning and layout for this and work was due to start shortly after our inspection.

Additionally, 97% of patients said they found the receptionists at the practice helpful compared to the national average of 87%. The practice 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 lead GP, who told us they would investigate these appropriately.

Care planning and involvement in decisions about care and treatment

The results from the National Patient GP survey which we reviewed showed that patients' responses were positive to questions about their involvement in planning and making decisions about their care and treatment. For example, 95% (compared to the national outcome of 86%) of practice respondents said the GP was good at explaining tests and treatments and 94% (compared to the national outcome of 82%) that the GP involved them in decisions about their care and treatment. Patients we spoke with on the day of our inspection told us that they felt listened to, and supported by, staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. They told us that staff were caring, took their concerns seriously and spent time explaining information in relation to their health and the treatment to them in a way that they could understand. Patient feedback on the comment cards we received was also very positive around involvement the care and treatment. Staff told us that the vast majority of patients registered with the practice were English speaking. Patient information was available in different languages on the practice website through a 'translate' facility.

Patient/carer support to cope emotionally with care and treatment

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

Good

Are services caring?

- 95% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 97% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 90%.

The practice had a system for ensuring that all staff were kept up to date on the status of palliative care patients. The lead GP would offer bereavement support if a bereaved patient attended the practice and provided proactive care at the palliative care patients' homes. Patients said they were given good emotional support by the GPs, and were supported to access support services to help them manage their treatment and care. The practice provided a flexible approach to consultations for vulnerable patients, often in their own environment for comfort and to ensure carers would be more likely to be available. Notices and information screens in the patient waiting rooms and patient website informed patients how to access a number of support groups and organisations. The practice's computer system alerted clinicians if a patient was also a carer.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood and was responsive to the different needs of the population it served and acted on these to plan and deliver services. The practice kept registers for patients who had specific needs including those with who were deemed vulnerable. These registers were used to monitor and respond to the changing needs of patients.

The practice utilised an electronic medical records system to record and collect information regarding patients. This ensured that they were offered consultations or reviews where needed. Examples of this included patients who needed a medication review and patients receiving palliative care.

The practice promoted independence and encouraged self-care for patients through the provision of printed and website information about healthy living. Care and support was offered on site and at patients' homes to ensure that the needs of patients were identified and met. The practice had a good longstanding working relationship with a community psychiatric nurse.

The practice had been particularly active in identifying those patients who were at risk of unplanned admission to hospital and who had tailored, individual care plans. The patients in this group were recorded on a register and the practice had a system in place for their care plans to be managed during monthly multi-disciplinary team (MDT) meetings. This enabled the practice to maintain an accurate picture of the evolving health needs of this group of patients. We saw that the practice made use of a number of initiatives to help manage the risk of admissions for these patients. The lead GP explained to us that he provided his personal contact details to those in the community that might have a need for advice outside normal practice hours to ensure continuity of care.

A volunteer home delivery service was available for medication from the dispensary. The facilities and premises were appropriate for the services which were planned and delivered, with sufficient treatment rooms and equipment available.

Patients recorded they were happy with the care and treatment they received. These findings were also reflected during our conversations with patients during our inspection. The lead GP explained that the long standing patient knowledge they had, allowed for recognition of changing needs in the community. For example the recognition of increasing frailty and loneliness in older people. This had led to the implementation of several community initiatives such as walking groups, bowling groups and social gatherings. The lead GP also provided anticipatory visits to older patients in the community.

The lead GP informed us he had provided for the printing of the local village magazine for a lengthy time. We were told by patients that the GP also organized occasional social gatherings, not always with a clinical incentive. The GP provided us with examples where they had organised community events and combined these with vaccination or health check awareness amongst patients.

Tackling inequity and promoting equality

The practice had taken account of the needs of different groups in the planning and delivery of its services. For example, we saw that the practice had a register of patients with a learning disability and a register of mental health patients. Such patients received an enhanced service where they were recalled for an annual, face-to-face health review.

The practice was housed in a purpose built building. Clinical treatment rooms were located on the ground floor. We saw that the premises' ground floor was configured in a way that enabled patients in wheelchairs to access ground floor consulting rooms. We saw evidence of a building plan which included the installation of an electric front door, increased space in the waiting room, additional space for prams and increased space around the reception area to increase patient confidentiality. This building work was due to commence shortly after our inspection.

We saw that the practice website had a translation facility which meant that patients who had difficulty understanding or speaking English could gain online access to information about the practice. The practice had access to the use of translation services if required. A hearing loop was available in the practice to support patients with hearing loss.

Staff we spoke with confirmed their understanding around the principles of equality and diversity.

Access to the service

GP consultations were available on Monday, Thursday and Friday between 08:30 and 11:00 and between 16:00 and

Good

Are services responsive to people's needs?

(for example, to feedback?)

17:30, on Tuesday between 08:30 and 11:00 and between 16:00 and 19:45 and on Wednesday between 08:30 and 11:00. Patients could attend the surgery during these hours to see a GP without the need to book an appointment. Booked appointments were available to see the nurse and health care assistants during aforementioned hours except for Tuesday afternoon.

Information was available to patients about appointments on the practice website. This included how to arrange home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Information on the out-of-hours service was provided to patients. Repeat prescriptions could be ordered online.

Patients were usually allocated standard appointment times with the GPs and the nurses. These were extended when necessary for patients with learning disabilities, long-term conditions, patients with poor mental health or those with complex needs.

A system was in place so that patients could receive home visits when required. Patients who were housebound or with limited mobility could also receive home visits and these were identified on the patient record system.

The patient survey information we reviewed showed patients always responded positively to questions about access to appointments. Overall they rated the practice highly in these areas. For example:

- 100% of respondents say the last appointment they got was convenient compared to the CCG average of 93% and national average of 92%.
- 99% described their experience of making an appointment as good compared to the CCG average of 77% and national average of 74%.
- 25% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 66% and national average of 65%. (The rationale behind this number being so low was that the practice operated without GP appointments and patients could attend when needed, which at times could lead to unpredictable waiting times. All the patients we spoke with and some of the comment cards confirmed this was not a concern and patients happily waited slightly longer if it meant they could be seen there and then).
- 100% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 74%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice's complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We were not shown any evidence that the practice reviewed complaints annually to detect themes or trends but did find that complaints were acted upon and dealt with appropriately. We looked at one complaint received in the last 12 months from a patient and found that it had been dealt with satisfactorily. We saw that information was available to help patients understand the complaints' system in the form of a leaflet and posters. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

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

Staff we spoke with were aware of the culture and values of the practice and told us patients were at the centre of everything they did. They felt that patients should be involved in all decisions about their care and that patient safety was also paramount. Comments we received were very complimentary of the standard of care received at the practice and confirmed that patients were consulted and given choices as to how they wanted to receive their care. The practice was engaged with the local clinical commissioning group (CCG) to ensure services met the local population needs. The lead GP attended meetings with this group on monthly basis. The lead GP was planning to retire three months after our inspection. Following that, it was planned that the practice would absorb another local practice through which internal processes and staff would be shared and improved.

Governance arrangements

There were arrangements in place to ensure the continuous improvement of the service and the standards of care. The policies and procedures were clear and accessible to staff. We saw evidence that processes and procedures were working in the practice. The practice used information from a range of sources including their Quality and Outcomes Framework (QOF) results and the Clinical Commissioning Group to help them assess and monitor their performance.

The lead GP had undertaken clinical audits which were used to monitor quality and systems to identify where action should be taken and drive improvements. These included antibiotic prescribing and dementia medication.

From a review of records including action points from staff meetings, complaints and significant event recording, we saw that information was reviewed to identify areas for improvements and to help ensure that patients received safe and appropriate care and treatments. Information around decisions derived from this process was shared verbally and at weekly staff meetings.

Monthly clinical governance meetings had recently been discontinued due to difficulties with having enough staff to attend. The lead GP raised this with us before the inspection and informed us this was planned to be taken up again once a proposed merger with another practice in October 2015 was completed. The lead GP dealt with governance matters on ad-hoc basis in the meantime.

Leadership, openness and transparency

Decision making and communication across the workforce was structured around key, scheduled meetings. Staff meetings covered general aspects of general practice and took place weekly. These meetings were not minuted but a staff book was kept which contained action points from these meetings.

Multidisciplinary team (MDT) meetings took place monthly; these meetings were coordinated by an area MDT coordinator and were attended by the practice and community services staff. The practice also attended prescribing meetings and monthly meetings with the local commissioning group.

Most staff told us that there was an open culture within the practice and they had the opportunity, and were happy to raise issues at weekly meetings. The GP informed us there were also occasional social evenings where practice related matters would be discussed. We reviewed a number of policies, for example the whistleblowing policy, recruitment policy and chaperone policy which were in place to support staff and up to date. Staff we spoke with knew where to find these policies if required. It was clear from our interviews with the GP and the staff that there was an open and transparent leadership style and that the whole team adopted a philosophy of care that put patients and their wishes first. Staff members we spoke with told us they felt their contribution to providing good quality care was valued.

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

There was a virtual patient participation group (PPG) in place with 125 members. Four of these members were proactively involved in arrangements and meetings. We spoke with a representative of the PPG who told us they felt that the practice was responsive to any issues raised by the group. An example provided was how the practice had responded to patients saying there was not enough parking by arranging a local agreement for practice staff to park at nearby facilities. They told us that the practice was

Are services well-led?

Good

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

very patient centred and had involved them in any proposed changes to the service. The practice website invited patients to become involved with their PPG and also shared the PPG report for 2013/14.

The majority of staff we spoke with told us they felt supported and happy to raise their concerns with their respective manager and were comfortable that these would be listened to and acted on.

Management lead through learning and improvement

The practice ensured its staff were multi-skilled and had learned to carry out a range of roles. This applied to clinical and non-clinical staff and enabled the practice to maintain its services at all times. For example, three members of staff could work both in the dispensary and at reception.

The majority of staff felt well supported and felt that their training needs were being met. The practice staff told us they worked well together as a team and there was evidence that staff were supported to attend training appropriate to their roles in most cases.

The GPs were all involved in revalidation, appraisal schemes and continuing professional development. There was evidence that staff had learnt from incidents and complaints. We were told that informal meetings took place to discuss specific issues but these were not recorded.