The Marches Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of The Marches Surgery on 27 October 2014. The practice also has a branch surgery at Bodenham which we did not inspect on this occasion. We found the Marches Surgery provided a good service to patients in all of the five key areas we looked at. This applied to patients across all age ranges and to patients with varied needs due to their health or social circumstances.

Our key findings were as follows:

- The practice had comprehensive systems for monitoring and maintaining the safety of the practice and the care and treatment they provide to their patients
- The practice was proactive in helping patients with long term conditions to manage their health and had arrangements in place to make sure their health was monitored regularly
- The practice was clean and hygienic and had robust arrangements for reducing the risks from healthcare associated infections
- Patients felt that they were treated with dignity and respect. They felt that their GP listened to them and treated them as individuals
- The practice had a well-established and well trained team and had expertise and experience in a wide range of health conditions

We saw several areas of outstanding practice including:

- The practice hosts a trained mental health worker and dementia nurse, both employed by 2gether Mental Health Trust, to work with patients.

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 report incidents and near misses. The practice provided opportunities for the staff team to learn from significant events and was committed to providing a safe service. Information about safety was recorded, monitored, appropriately reviewed and addressed. The practice assessed risks to patients and managed these well. There were enough staff to keep people 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. Patients' care and treatment took account of guidelines issued by the National Institute for Care and Health Excellence (NICE). Patients' needs were assessed and care was planned and delivered in line with current legislation. The practice was proactive in the care and treatment provided for patients with long term conditions and regularly audited areas of clinical practice. There was evidence that the practice worked in partnership with other health professionals. Staff received training appropriate to their roles and the practice supported and encouraged their continued learning and development.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients told us they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We saw that staff treated patients with kindness and respect and were aware of the importance of confidentiality. The practice provided advice, support and information to patients, particularly those with long term conditions, and to families following bereavement. We learned that the practice was 'Highly Commended' in Herefordshire Carer Support's 2013 awards for carer support by GP practices.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice was aware of the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and said that urgent appointments were available the same day.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. There was a clear complaints system with evidence demonstrating that the practice responded quickly to issues raised. The practice had a positive approach to using complaints and concerns to improve the quality of the service.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had an open and supportive leadership and a clear vision to continue to improve the service they provided. There was a clear leadership structure and staff felt supported by management. The practice had well organised management systems and met regularly with staff to review all aspects of the delivery of care and the management of the practice. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this was acted upon. The practice had a patient participation group (PPG). The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. There was evidence that the practice had a culture of learning, development and improvement.

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

This practice is rated as good for the care of older patients. Patients over the age of 75 had a named GP and many were included on the practice's 'avoiding unplanned admissions' list to alert the team to people who may be more vulnerable. The GPs carried out visits to patient's homes if they were unable to travel to the practice for appointments. The practice was in the process of delivering its 'flu vaccination programme. The practice nurse was arranging for these to be done at patient's homes if their health prevented them from attending the clinics at the surgery. The practice worked with seven local care homes to provide a responsive service to the patents who lived there.

People with long term conditions

Good

This practice is rated as good for the care of patients with long term conditions, for example asthma and diabetes. The practice had effective arrangements for making sure that patients with long term conditions were invited to the practice for annual and half yearly reviews of their health. Members of the GP and nursing team at the practice ran these clinics. The practice had a specialist diabetes nurse.

Patients whose health prevented them from being able to attend the surgery received the same service from one of the district nurses who arranged visits to them at home (including patients in the seven care homes the practice supports). Patients told us they were seen regularly to help them manage their health.

Families, children and young people

Good

This practice is rated as good for the care of families, children and young people. The practice held weekly childhood vaccination clinics for babies and children. Child flu vaccinations were also provided. A midwife came to the practice weekly to see expectant mothers. The practice provided a family planning service.

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age patients, recently retired people and students. The practice had arrangements for people to have telephone consultations with a GP if needed. One GP specialised in musculoskeletal conditions, sports injuries and sports medicine.

Summary of findings

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of patients living in vulnerable circumstances. One of the GPs was the lead for learning disability (LD) care at the practice and the practice had an LD register. All patients with learning disabilities were invited to attend for an annual health check. Staff told us that the practice did not have many travelling individuals or families currently registered at the practice, although this had been greater in the past. We learned that when homeless people came to the practice the team provided appropriate care and treatment and supported them with establishing a correspondence address if possible. The practice was part of the local GP prescribing scheme for drug dependency.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). The practice hosts a mental health worker, had a register of patients at the practice with mental health support and care needs and invited them for annual health checks. Staff described close working relationships with the local mental health team which worked with the practice to identify patients' needs and to provide patients with counselling, support and information. The practice hosts a specialist dementia care nurse.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 43 CQC comment cards patients had filled in and by speaking in person with seven patients, one of whom was involved with the Patient Participation Group (PPG). Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience. Data available from the NHS England GP patient survey showed that the practice scored in the middle range nationally for satisfaction levels.

All patients were positive about their experiences at The Marches Surgery. They told us that they were treated with respect and the GPs, nurses and other staff were kind, sensitive and helpful. Several patients expressed appreciation for the service they had received, some in particularly difficult circumstances.

Ten patients wrote specific comments about the appointment system. They confirmed they were always able to get same day appointments when needed.

Outstanding practice

- The practice hosts a trained mental health worker and dementia nurse, both employed by 2gether Mental Health Trust, to work with patients.

The Marches Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Keith Briant

Background to The Marches Surgery

The Marches Surgery provides primary care services for 8,850 patients in Leominster and the surrounding area. It is located in a rural area with a large elderly population.

The practice has six GP partners, a salaried GP, a practice manager, three practice nurses, two healthcare assistants, a phlebotomist (who carries out blood tests), along with receptionists and other staff who provide administrative support. There is a branch surgery at Bodenham which has a dispensary. Patients are free to book appointments at either practice.

The practice does not provide an out of hours service to their own patients. Patients are provided with information about the local out of hours services based in Hereford which they can access by using the NHS 111 phone number.

Services were provided from The Marches Surgery, Westfield Walk, Leominster, which we visited for our inspection. We did not visit the branch surgery.

The Care Quality Commission (CQC) has not had previous concerns about the practice.

The Marches Surgery provides a range of NHS services including blood testing, chiropody, physiotherapy and anti-coagulant testing. Bereavement and counselling sessions are held there.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

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

Before this inspection, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. These organisations included Herefordshire Clinical Commissioning Group (CCG), NHS England local area team and Herefordshire Healthwatch. We carried out an announced visit on 27 October 2014. During the inspection we spoke with a range of staff (GPs, nurses, practice manager, reception and administrative staff). We spoke with seven patients who used the service, one of whom was a member of the Patient participation Group (PPG).

Detailed findings

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 living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the patient recall procedure was revised after a follow-up appointment had been missed.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. We were shown records that demonstrated information gained from clinical audits and health and safety audits was assessed with patient safety in mind.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last five years and we were able to review these. Significant events were regularly reviewed in dedicated meetings. Actions from past significant events and complaints were also reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We were shown the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of an incorrect medication dosage having been prescribed. The practice had ensured there had been no risk to the patient. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated in staff meetings 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. For example, changes to diabetes medicine prescribing. They also told us alerts were discussed during meetings held for clinical staff to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. We were shown training certificates to demonstrate this. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. All nursing staff, including health care assistants and reception staff had been trained to be a chaperone. We spoke with one patient who had recently been chaperoned during an appointment. They were very complimentary about the experience.

Systems were in place to identify potential areas of concern. For example, to identify children and young people with a high number of accident and emergency attendances and the follow up of children who persistently fail to attend appointments e.g. for childhood immunisations.

The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the local authority.

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. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic prescribing within the practice.

We saw there were Patient Group Directions (PGD) in place to support the nursing staff in the administration of vaccines. A PGD is a written instruction from a qualified and registered prescriber, such as a doctor, for a nurse or appropriately trained person to administer a medicine to groups of patients without individual prescriptions. We saw the PGDs had been signed by all the nurses who administered the vaccines and authorised by a manager. This meant that staff and managers were informed of any changes to the PGD. There was also a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out an audit during October 2014 and annually in previous years.

Any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. The most recent infection control audit had not raised any concerns.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. They included the safe use and disposal of sharps; use of personal protective equipment (PPE); spills of blood and bodily fluid amongst others.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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

There were arrangements in place for the safe disposal of clinical waste and sharps, such as needles and blades. We saw evidence that their disposal was arranged through a suitable company. The practice employed their own cleaner for general cleaning of the practice. We were shown the cleaning schedules and checklists for this and saw there was a regular audit of cleaning undertaken.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales.

Staffing & Recruitment

We were shown how the practice ensured there were sufficient numbers of suitably qualified, skilled and experienced staff on duty each day. There was a staff rota

Are services safe?

throughout the week and always a member of clinical staff on duty. Some administrative staff were part time, so staff cover was also available if a staff member was unexpectedly absent.

We saw how the practice had monitored their workforce and reviewed their workforce requirements to ensure sufficient staff were available to meet the needs of the population they served. Management confirmed they had sufficient staff on duty throughout the week. At the time of our inspection, the practice had advertised for a business administration apprentice to specialise in this work along with other duties.

We looked to see what guidance was in place for staff about expected and unexpected changing circumstances in respect of staffing. We saw a selection of policies and procedures in place, for example, staff sickness, and planned absences. We saw how the practice would ensure staff absence was managed in a fair and consistent way to ensure the impact on the practice was minimised.

We saw how if a shortfall of doctors ever occurred, for example, as a result of sickness, locum doctors could be used. A service level agreement was in place to monitor this with the agency who supplied the locums. We were shown the business continuity plan which had been adopted by the practice which advised what to do should there be 'Incapacity of GPs and practice staff'. This would help to ensure sufficient availability of doctors to continue the primary care service provision to patients.

The practice had a comprehensive and up-to-date recruitment policy in place which included a full skills assessment. The policy detailed all the pre-employment checks to be undertaken on a successful applicant before that person could start work in the service. This included identification, references and a criminal record check with the Disclosure and Barring Service (DBS). We looked at a sample of recruitment files for doctors, administrative staff and nurses. They demonstrated that the recruitment procedure had been followed. All staff were issued with a staff handbook which covered every area of the practice and staff roles.

Additionally, the practice was also a teaching practice which hosted and trained GP registrars and university medical students. It also hosts sixth form work experience students. We saw evidence that the training received by medical students is highly rated.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed during staff meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example there were emergency processes in place for patients with long-term conditions, such as asthma and diabetes.

Arrangements to deal with emergencies and major incidents

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

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified

Are services safe?

included power failure, adverse weather, including flooding, unplanned sickness and access to the building. The practice had carried out a fire risk assessment that included actions required to maintain fire safety.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment, care & treatment in line with standards

Patients' needs were assessed and care and treatment was planned and delivered in line with their individual wishes. All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment.

Clinical staff managed the care and treatment of patients with long term conditions, such as diabetes, asthma and hypertension (high blood pressure). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis.

Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Their details were passed to the out of hours service to ensure care would continue when the practice was closed. Families were on occasion, given personal telephone Families were given personal telephone numbers of GPs for patients at the final stages of end of life care so they could be contacted at any time. We saw appropriate consent had been obtained for this.

Staff showed us how they used the National Institute for Health and Care Excellence (NICE) templates for processes involving diagnosis and treatments of illnesses. NICE guidance supported the surgery to ensure the care they provided was based on latest evidence and of the best possible quality. Patients received up to date tests and treatments for their disorders. We saw records of meetings that demonstrated revised guidelines were identified and staff trained appropriately.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included Chronic Obstructive Pulmonary Disease (COPD) and diabetes. Dates had been set to repeat these audits to determine their effectiveness. We found the monitoring the practice had carried out included chronic conditions and how the practice was organised. We saw evidence where staffing levels had occasionally been changed as a result of the latter. Some of this monitoring was carried out as part of the Quality and Outcomes Framework (QOF). This is an annual incentive programme designed to reward doctors for implementing good practice. The practice demonstrated they were meeting the expected targets and was high performing.

The practice was able to identify and take appropriate action on areas of concern. For example, with a large number of elderly patients registered at the practice, the practice hosted a foot care clinic.

We also saw evidence the practice manager attended peer group meetings with other practice managers to identify and discuss best practice. We saw learning was shared in an appropriate way and recorded in the meeting minutes.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, one staff member had recently completed an NVQ3 in Business Administration and Customer Service which was relevant to their job role.

As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses were expected to perform defined duties which were outlined in their job description and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines. We were shown certificates to demonstrate that they had appropriate training to fulfil these roles.

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately. Any concerns were raised in clinical staff meetings.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented.

We saw records that confirmed the practice worked closely with the community midwife service, health visitors, community mental health professionals and community drug teams. Clinics were held for blood testing, dermatology, chiropody, physiotherapy and anti-coagulant testing within The Marches Surgery to which patients were referred.

Within the waiting room there was a large range of information leaflets about local services. Some of this information was available in other languages on request. Leaflets in other languages were not routinely displayed and almost all patients spoke English.

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. Electronic systems were also in place for making referrals, and the practice made many of its referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. 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

There were mechanisms to seek, record and review consent decisions. We saw there were consent forms for patients to sign agreeing to minor surgery procedures. We saw that the need for the surgery and the risks involved had been clearly explained to patients.

We saw signed consent forms for children who had received immunisations. The practice nurse was aware of the need for parental consent and what action to follow if a parent was unavailable. There was information available for parents informing them of potential side effects of the immunisations. The GPs and nurses that we spoke with demonstrated a clear understanding of the importance of determining if a child was Gillick competent especially when providing contraceptive advice and treatment. A Gillick competent child is a child under 16 who has the legal capacity to consent to care and treatment. They are capable of understanding implications of the proposed treatment, including the risks and alternative options. The practice had access to interpreting services to ensure patients understood procedures if their first language was not English.

Staff we spoke with had an understanding of the Mental Capacity Act 2005 and demonstrated knowledge regarding best interest decisions for patients who lacked capacity. Mental capacity is the ability to make an informed decision based on understanding a given situation, the options available and the consequences of the decision. People may lose the capacity to make some decisions through illness or disability.

Health Promotion & Prevention

We saw all new patients were offered a consultation with a healthcare assistant when they first registered with the practice. If any medical concerns were found, the patient

Are services effective?

(for example, treatment is effective)

was referred to the GP or another healthcare professional if more appropriate. The practice also offered NHS Health Checks to all its patients aged 40-75. The practice's performance for cervical smear uptake was similar to others in the Clinical Commissioning Group (CCG) area.

We were shown work the practice had carried out to identify and promote particular health needs within the area. This mainly centred on the large elderly population and had led to the introduction of a foot health care clinic.

The practice also specialised with an enhanced musculosketal and sports medicine provision. This was led by a partner GP with a particular interest and qualification within this area.

The practice actively participates in Primary Care Research, through the Primary Care Research Network (PCRN). We saw evidence that it is the only practice in the county to participate in the PCRN scheme, requiring involvement in a minimum of three research studies each year.

The practice is a "spotter practice" for the national annual flu monitoring scheme.

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

All patients we spoke with were very happy with the care they received and any follow-up needed once they obtained an appointment. All patients felt they were consistently treated with dignity and respect by all members of staff. During our inspection we observed, within the reception area, how staff interacted with patients, both in person and over the telephone. Staff were helpful and empathetic, warm and understanding towards patients. Staff we spoke with told us patient care was at the centre of everything they did and their behaviours displayed this at all times.

In March 2014, 211 patients completed a short questionnaire, issued by the practice. Of those patients who responded, 99% said they found staff at the practice very friendly and helpful. This sample represented 2% of the patient list.

We saw that patients' privacy and dignity was respected by staff during examinations. We saw curtains could be drawn around treatment couches in consultation rooms. This would ensure patients' privacy and dignity in the event of anyone else entering the room during treatment.

Care planning and involvement in decisions about care and treatment

We looked at patient choice and involvement. Staff explained how patients were informed before their treatment started and how they determined what support was required for patients' individual needs. Clinical staff told us they discussed any proposed changes to a patient's treatment or medication with them. They described treating patients with consideration and respect and said they kept patients fully informed during their consultations and subsequent investigations. Patients we spoke with confirmed this. Patients had the information and support available to them to enable them to make an informed decision about their care and treatment needs.

Patients told us that their GP listened to them and gave us examples of advice, care and treatment they had received.

A number of people confirmed their GP or nurse gave them information, fully discussed their health needs and explained the 'pros and cons' of the options available to them. Some patients indicated that they had long term health conditions and said that they were seen regularly.

GPs recognised the importance of patients understanding their care and treatment needs and gave examples of situations where they had done their best to give patients clear information.

Patient/carer support to cope emotionally with care and treatment

Some of the information we received was from patients who were also carers. In these cases patients described the support and compassion they and their relative had received from the team at the practice. Other patients also described feeling well supported emotionally by the practice.

When patients died the practice contacted families to check their well-being and to offer the opportunity to speak with a member of the team. Information was provided about organisations specialising in providing bereavement support.

The practice had a carers' lead as recommended by Herefordshire Carer Support (HCS) an organisation that provides support and guidance to carers in Herefordshire. The practice had a carers' noticeboard and shelves in the waiting room which contained a wide range of information including details about Herefordshire Carer Support. We learned that the practice was 'Highly Commended' in Herefordshire Carer Support's 2013 awards for carer support by GP practices and encouraged patients to find out more about HCS and the support they provided. When the practice held a weekend 'flu vaccination clinic they arranged for a representative from HCS to be there to meet patients. As a result of this several people registered with HCS on the day. The practice held a joint 'Carers' Week' with Westfield Surgery, the other GP practice in the same building. This had included a lunchtime event for carers attended by HCS, staff from the local Hospice and from Age Concern.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, the practice had a register of patients with mental health support and care needs. Each person on the register was invited for an annual review. Staff explained that they had good working relationships with the local mental health team. The practice hosted a trained mental health worker and a dementia trained nurse to work with relevant patients.

The practice planned its services carefully to meet the demand of the local population. We saw minutes of meetings that demonstrated regular meetings were held to discuss capacity and demand. As a result of this, changes were made to staffing and clinic times when required. Services were also reviewed in the wider context of the local health economy. Review meetings were held with the Clinical Commissioning Group (CCG) and a GP attended these.

The practice provides general practice cover to people living in seven local care homes. We spoke with management at three of these care homes about the service people received from The Marches Surgery. All three were positive about the service. They told us that a GP regularly visits the homes as needed. We were told it was often the same GP who visited and that this provided welcome continuity. They told us that the GPs were polite, respectful and kind to their patients and listened to them. Care home management confirmed the GPs worked with them to review each person's medicines.

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patients 'views were included in the design and delivery of the service. We saw how the PPG played an active role and was a key part of the provider's organisation. Regular meetings were held. We saw how the PPG had been involved with promoting booking appointments on-line.

Tackling inequity and promoting equality

Most patients who used The Marches Surgery spoke English as their primary language. However, staff explained the telephone interpreting service they used for patients who were unable to converse with ease in English. The system was easy to use and accessible and the reception staff who showed it to us was knowledgeable about how to use it. We noted that information leaflets in the practice were only available in English. However, GPs also had the facility to print up to date NHS patient information leaflets during consultations with patients and it was possible to select other languages for this.

The practice did not have an induction loop to assist people who use hearing aids, but explained how they would handle patients with a hearing impairment, for example, they could take them into a quieter private room to aid the discussion if required.

Access to the service

The practice opened from 8am to 6pm every weekday. Outside of these times and during the weekend, an out of hours service was provided by another provider located in Hereford. Telephone calls were automatically directed to the NHS 111 service. This ensured patients had access to medical advice outside of the practice's opening hours. At the time of our inspection, the practice had joined a local GP federation. This organisation already used the Marches Surgery outside of normal practice opening hours to host patient appointments from the local area.

Appointments could be booked for the same day, for within two weeks time or further ahead. For patients who had an urgent medical condition that could not wait until the next routine appointment, the practice added additional appointments to the end of each surgery slot. Patients could make appointments and order repeat prescriptions through an on-line service. Home visits were available for patients who were unable to go to the practice.

In March 2014, 211 patients completed a short questionnaire, issued by the practice. Of those patients who responded, 80% were able to get an appointment to see or speak to someone easily. This sample represented 2% of the patient list.

Are services responsive to people's needs?

(for example, to feedback?)

The information from CQC comment cards and patients we spoke with indicated that the service was generally accessible and that patients were able to get an appointment on the same day they phoned if this was needed.

Listening and learning from concerns & complaints

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

We were shown how patients' concerns were listened to and acted upon. There was information about how to complain displayed in the waiting area and within the patient information pack. All of the patients we spoke with said they had never had to raise a formal complaint. The complaints procedure identified how complaints would be dealt with. It also identified the timescales for responding to and dealing with complaints. The practice also had a complaints summary which summarised the complaints for each year. This was used to identify any trends. Details of the complaints procedure were displayed in the waiting room and within the patient information pack.

We looked to see whether the practice adhered to its complaints policy and we reviewed two patient complaints in detail. We found that the complaints had been dealt with appropriately and within the timescales set out in the practice's complaints policy.

It was also clear that verbal complaints were dealt with in the same way as written complaints. If a patient telephoned the practice to complain, the practice manager would immediately take the call if available.

Are services well-led?

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

Our findings

Vision and Strategy

In discussion with staff, it was evident that the team at the practice shared a desire to provide patients with a safe and caring service where people were treated with dignity and respect. The GP partners held regular partners' meetings to discuss important issues such as forward planning, practice objectives and staff morale. The practice regularly reviewed its objectives at staff meetings and they were on target.

We heard that the staff team arranged social activities and that these were also used to celebrate and reward staff achievements.

Governance Arrangements

The GP partners all had lead roles and specific areas of interest and expertise. This included governance. During the inspection we found that all members of the team we spoke with understood their roles and responsibilities. There was an atmosphere of teamwork, support and open communication. The practice held a fortnightly clinical forum and regular discussions about any significant event analyses (SEAs) that had been done. All of the clinical staff attended these meetings and where relevant, other staff also took part in the discussions about SEAs. This helped to make sure that learning was shared with appropriate members of the team. The practice held quarterly half-days for training and team building.

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. We saw examples of completed clinical audit cycles, such as vitamin B12 injections. This demonstrated the practice reviewed and evaluated the care and treatment patients received.

Leadership, openness and transparency

The practice had a team of partners, some of whom had worked together over a number of years to provide stable leadership. They were supported by a practice manager who was described by clinical and other staff as playing a positive and key role in the management of the practice. Staff told us they felt well supported and that all of the partners were approachable. Staff also confirmed that the practice manager had an 'open door' policy. One of the staff we spoke with told us that The Marches Surgery was a caring and well led place to work where morale was high.

Practice seeks and acts on feedback from users, public and staff

The practice had an established Patient Participation Group (PPG) in place. The purpose of the PPG was to act as an advocate on behalf of patients when they wished to raise issues and to comment on the overall quality of the service. This ensured patients' views were included in the design and delivery of the service. The chair of the PPG told us the group played an active role and was a key part of the practice's organisation. The PPG action plan for 2014 gave examples of activities the PPG was involved with. This included promoting and increasing the use of on-line appointment booking and meeting with local MPs and county councillors to discuss local parking problems which were a concern for some patients.

All staff were fully involved in the running of the practice. We saw there were documented regular staff meetings. This included meetings for clinical staff and meetings that included all staff. This ensured staff were given opportunities to discuss practice issues with each other. There was a clear culture of openness and 'no blame' in place. This meant staff could raise concerns without fear of reprisals and the practice's whistleblowing procedure supported this.

The practice asked patients who used the service for their views on their care and treatment and they were acted on. This included the use of surveys to gather views of patients who used the service. We saw there were systems in place for the practice to analyse the results of the survey for information so that any issues identified were addressed and discussed with all staff members. We saw records of discussions within the minutes of staff meetings. All the patients we spoke with on the day of our inspection told us they received a high quality service from the practice. It was clear patients experienced the quality of service that met their needs.

Management lead through learning & improvement

We saw evidence that the practice was focussed on quality, improvement and learning. There was a well-established staff development programme for all staff within the practice, whatever their role.

The whole practice team had sessions four times each year for 'protected learning'. This was used for training and to give staff the opportunity to spend time together. Topics such had customer service skills and information

Are services well-led?

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

technology changes had been covered. Cover for the practice was provided by a locum GP during this time. The practice had a quarterly training session and practice nurses had one week of study leave every year to use for their professional development to ensure they were fully conversant with the latest nursing developments.

The results of significant event analyses and clinical audit cycles were used to monitor performance and contribute to staff learning.