Greyfriars 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 an announced comprehensive inspection of this practice on 27 October 2014.

We have rated this practice as good overall. We found the practice to be good in the safe, effective, caring, responsive and well-led domains. We found the practice provided good care to older people; people with long term conditions; families, children and young people; the working age population and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

Our key findings were as follows:

- Patients were positive about the helpfulness, care and treatment provided by all the staff at Greyfriars Surgery.
- Patients received safe care because information about safety was recorded, monitored, reviewed appropriately and addressed.
- The practice team understood the needs of their patient population and staff worked flexibly to ensure that every patient could access the best possible care.
- The practice had established a learning culture for the benefit of all groups of staff and for patients.

However the provider should:

- Ensure that there is clear evidence that patients' consent has been sought and obtained before minor surgery is undertaken.

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 people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

Staff had received training appropriate to their roles and any further training needs have been identified and planned. The practice could identify appraisals and the personal development plans for all staff. The practice was innovative and proactive in improving patient outcomes. GPs maintained specialist interests and linked with other local providers to share best practice. The practice team worked positively with a range of 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 several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand.

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

Summary of findings

NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they could make an appointment with a named GP and that when they needed urgent care, same day appointments were available.

The practice was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. There was evidence that all staff discussed complaints and learned from them.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by 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. The patient participation group (PPG) provided feedback to staff. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

Patients aged over 75 have a named GP for continuity of care. GPs made home visits to patients when they needed them. Patients who lived in care homes benefited from a weekly visit by a named GP with telephone contact to follow up patients.

Feedback from a care home manager described improved continuity of care for patients who lived in the care home as a result of having a nominated GP. They also referred to excellent response times when the manager had concerns about their resident patients and very high standards of palliative care to ensure those patients' needs were met at the end of their life.

People with long term conditions

Good

Nurses who have received specialist training provide care for patients with long-term conditions such as diabetes and respiratory disease. Patients were reviewed annually or, in the case of patients with diabetes, twice a year.

Patients with Type 2 diabetes were supported by the practice to make the transition from oral medicines to injectable medicines when they need to. This enabled them to have continuity of care from the practice. The practice has supported patients with chronic obstructive airways disease to have greater input in managing their condition through using on-line access to their records. The practice team included a GP who was also a cardiologist and continued to work in that specialism.

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 of poor health outcomes. The practice provided a baby clinic and appointments were available outside of school hours.

The premises were suitable for children and babies. We saw good examples of joint working with midwives and health visitors. Emergency processes were in place and referrals were made for children and pregnant women whose health deteriorated suddenly.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice works flexibly to ensure the services it offered were accessible and offered continuity of care.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients who needed end of life care and offered these patients a caring and compassionate service from a named GP of their choosing. The practice held a register of patients with a learning disability. It had set up systems for carrying out annual health checks for this group and had completed annual reviews. Appointments were flexible so that patients had enough time to express any concerns they had. The practice offered 'shared care' in conjunction with a local team who supported patients with alcohol and substance abuse problems.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It provided information about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and 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 to support patients experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia and provided appropriate information for them or referred them to other teams.

Summary of findings

What people who use the service say

During our inspection we spoke with nine patients and two carers. The patients we spoke with told us they were treated with kindness, consideration and respect by all staff. Their dignity was maintained at all times. They said that GPs and nurses were supportive and understood their concerns. A disabled patient described how staff helped them to get around the building to ensure they felt safe. The carers we spoke with told us that the patients they cared for were happy with the services provided by the practice and said that as carers they were shown the same level of consideration and respect as patients. Every patient we spoke with was positive about the care they received.

Thirty patients had completed comment cards to tell us about their care. We reviewed their comments and found that patients were positive about the care they received, with some describing their care as excellent. Comments included references to GPs and nurses listening to patients. A temporary patient praised the service they had received which had alleviated anxiety for them.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that there is clear evidence that patients' consent has been sought and obtained before minor surgery is undertaken.

Greyfriars Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

The inspection team was made up of a GP special advisor, a practice manager special advisor and a CQC inspector who led the inspection.

Background to Greyfriars Surgery

Greyfriars Surgery provides a primary medical service to patients who live within the city of Hereford or in some of the surrounding villages. The practice population reflects the average patient population for England in respect of social deprivation. The practice has estimated that the majority of its patients speak English.

The practice has one female and three male GP partners. It is a training practice and when we visited, a GP registrar was undertaking their specialist training to become a GP there. The practice employs a nurse practitioner, three practice nurses and two healthcare assistants, all of whom are female. A practice manager leads a team of reception and administrative staff.

The practice has a contract to provide general and enhanced medical services.

We have not received any information describing concerns about this practice.

This practice does not provide out of hours care to its patients. The Herefordshire Clinical Commissioning Group (CCG) contracts with other providers to provide out of hours care for all patients living in the county. The Greyfriars Surgery website and leaflet advise patients to telephone 111 if they need urgent medical care when the surgery is closed.

The GPs at Greyfriars Surgery together with other GPs across the Herefordshire CCG area owned and managed an extended hours service. Patients were able to book appointments with this service from the practice.

Why we carried out this inspection

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

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

This provider had not been inspected before and that was why we included them.

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.

Detailed findings

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations, including the Clinical Commissioning Group (CCG) for Herefordshire, to share what they knew.

We carried out an announced visit on 27 October 2014. During our visit we spoke with a range of staff at the practice including three GPs, the practice manager, nurses and administrative and reception staff. We spoke with nine patients and two carers. We observed how people were being cared for and reviewed a range of documents. We reviewed comment cards left for us by patients.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

We saw that the practice had systems in place to assess and monitor the consistency of their performance over time. We saw that they had followed up six specific incidents in the practice this year and had taken steps to ensure that they understood whether each incident related to an error or a failure in one of their systems. We saw that action was taken to reduce the risk of safety events. For example, we saw that in one incident, a mistake had been made in the communication of some information. To prevent a recurrence of this, a clear note was added to the patient's records.

We saw that multiple sources of information were used by the practice to check the safety of the service and action was taken to address any areas in need of improvement. We saw for example that the practice had responded quickly to national alerts to all practices about being prepared for any possible incidence of Ebola and had set up a template to guide them in providing safe care for patients, staff and the public should the need arise. We saw that one GP had seen two patients with an unusual condition. This had prompted them to identify other patients with similar symptoms and to review how different GPs coded their diagnosis in patient records and the impact of this on treatment plans.

We found clear procedures were in place for reporting safety incidents, complaints or safeguarding concerns. Staff we spoke with knew it was important to report incidents and significant events to keep patients safe from harm. Staff told us they were actively encouraged and supported to raise any concerns that they might have. The practice manager told us that the no-blame culture within the practice supported an open and honest approach if someone made a mistake.

We reviewed available data in respect of identified risks for patients who used Greyfriars Surgery. We found that no risks to patient safety had been identified.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every three months to review actions from past significant events and complaints. One of the GPs told us that reviews of events were always linked to education for staff with an emphasis on what could be done differently to improve patient care. There was evidence that the outcomes from analysis of events and complaints were shared with relevant staff within the practice and that protocols were developed as a result. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they told us they were encouraged to do so.

The practice manager showed us the system she used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. 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 to practice staff through an electronic documents management system. We saw that the system prompted clinicians and other staff to include information in the weekly clinical meetings. For example we looked at the diary of clinical meetings and saw that a review of the electronic document system was scheduled and on another occasion, a review of specific medicines.

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. Members of the staff team spoke with us about their involvement in child safeguarding. We found that the staff we spoke with understood their responsibilities in respect of safeguarding both children and adults. They knew who to contact in the practice if they had concerns and they had access to the contact details for the relevant external agencies.

The practice had appointed a dedicated GP as their safeguarding lead for children and vulnerable adults. All the GPs had attended training at an advanced level in safeguarding children and vulnerable adults.

The practice used the EMIS system for patients' electronic records. If there were concerns about the safety of a patient, the practice manager reviewed the information and coded the record accordingly. The system generated

an alert to indicate that confidential information was available for GPs to view. This ensured that only GPs or other staff who needed to know had access to sensitive information about patients and that patients who were vulnerable had their privacy respected as much as possible.

Children and families who had been identified as at risk of harm or disadvantage and children who had missed immunisations were regularly reviewed with health visitors who attended a monthly meeting at the practice. The GPs provided reports when requested when they were unable to attend meetings about vulnerable patients.

Every patient who received repeat prescriptions for medicines was reviewed at regular intervals according to the type of medicine. The EMIS computerised system generated an alert to guide practitioners about time scales for reviews. EMIS is a computerised system that allows healthcare professionals to record, share and use patient information to help provide better and more efficient care.

There was a chaperone service provided by nurses. Information about this was visible in the waiting rooms.

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. A senior nurse told us that practice staff followed the policy. We saw that fridges used to store vaccines and other medicines were set to operate within the appropriate temperature range. We saw that daily checks were made to monitor the fridge temperatures and weekly checks were made to ensure the fridges were accurately calibrated. A process improvement tool used by the Clinical Commissioning Group (CCG) had been applied to the storage and transportation of vaccines at Greyfriars Surgery. The outcome was that the practice was found to have a very high compliance score of 93%.

Processes were in place to check medicines were within their expiry date and suitable for use. We saw records which indicated that medicines were checked weekly. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw a range of records which confirmed that clinicians reviewed patterns of prescribing and followed relevant guidance, for example in respect of medicines for diabetes and for osteoporosis.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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 visibly clean and tidy. We saw there were cleaning schedules in place and some 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 nurse for infection control who had undertaken 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 that the cleaners had completed infection control training. Monthly audits of cleaning had not been comprehensively completed by practice staff; however, when the CCG completed an audit for infection control at Greyfriars Surgery in June 2013, we saw that the practice had achieved a high score. We saw that the practice had recorded their actions in respect of recommendations, from the audit, for developing their systems.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use.

Good

Are services safe?

There was a policy for needle stick injury, which was visible in each treatment room. 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.

Equipment

Staff 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, including the compliance certificate for blood pressure monitors used by patients at home.

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 the fridge thermometer.

Staffing and recruitment

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

The practice manager told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for administrative and reception staff and arrangements were made so that members of these teams covered each other's annual leave. The practice manager told us that their good reputation as a primary medical care provider ensured that they did not experience difficulties in recruiting nurses and that members of the nursing team worked additional hours to cover leave or other absences. Contingency plans were in place to ensure the practice functioned safely during bad weather when more staff might be absent. The plans included prioritising the workload and seeking 'buddy' support from another practice.

The GPs told us the practice had experienced a shortage in their GP hours and used locum GPs when they needed to. We saw that the Locum Agreement used by the practice described the expectations of the locum GP and the duties of the practice manager to make checks with the General Medical Council (GMC) and other bodies that the locum GP was appropriately qualified and registered. They had recently appointed a new GP partner and a new salaried GP who had completed registrar training at the practice.

The staff we spoke with confirmed that there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

The practice manager had completed training in managing health and safety and had completed risk assessments for the practice. They had identified risks and assessed to patients, staff and visitors to the practice and put strategies in place to reduce risks. For example, we looked at the risk assessments relating to staff who were pregnant. We saw that a range of health and safety checks and strategies were in place to reduce risks including checks of the building, medicines management, staffing, dealing with emergencies and equipment. Health and safety training for all staff had been set up and information about reducing risks was displayed in the practice.

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 at GP partners' meetings and within team 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. Examples of this were: a care home manager had reported that the GPs responded quickly to provide care for older patients; there were processes in place for identifying acutely ill children and young people, including a 'traffic light' system to prompt awareness and rapid response; the practice had

stratified the levels of risk to their patients and had developed care plans for the 2% of their patients who had the highest risk of hospital admission and the practice monitored repeat prescribing for people receiving medication for mental ill-health.

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. Resuscitation equipment, oxygen and emergency medicines were located in the reception area and all staff knew of their location. A defibrillator (used to attempt to restart a person's heart in an emergency) was accessible.

There were processes 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. The defibrillator had been tested during 2014. One set of pads for the defibrillator was out of date; the practice took immediate steps to obtain new ones. The equipment in the resuscitation box was in date.

A detailed 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 clarified and a series of actions to reduce or manage risks were clearly described for staff to follow. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the electricity provider should the supply of electricity fail. Copies of the plan were held outside the practice building by key staff.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that one member of staff had completed additional training as a fire warden. Alarms were checked weekly; fire drills took place and fire extinguishers were maintained regularly.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that new guidelines were disseminated by the practice manager and members of the administrative team. GPs told us they discussed the implications of these for patients at the weekly clinical meeting and during their daily informal meetings. Actions required were recorded.

We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with NICE guidelines and these were reviewed when appropriate. For example, the GPs' audits described thorough assessments of patients' medication with follow up reviews. We were told that patients who had complex health needs had enhanced care plans. We saw that GPs referred patients who needed secondary care promptly and followed up their care afterwards with appropriate treatment.

The GPs told us they had developed specialist clinical areas of interest such as diabetes, heart disease and palliative care. The practice nurses supported this work. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

We looked at national data about the performance of primary medical care practices. We found that Greyfriars practice had achieved better than average scores in most indicators, including the percentage of patients who had a comprehensive care plan agreed between them, their family and/or their carers.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing safety alerts and medicines management. The information staff collected was then collated by the practice manager or clinicians to support the practice to carry out clinical audits. The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). QOF is a national performance measurement tool.

We looked at five clinical audits that had been undertaken since 2012. These were completed audits where the practice was able to demonstrate the developments in patient safety since the initial audit. One audit was in response to an alert by the National Institute of Health Care Excellence (NICE) about prescribing specific medicines for patients at risk of bone fractures. All the patients taking the medicine were identified and reviewed. Their prescribed medicines were changed in line with recommendations or they were referred to a specialist clinic for further advice. All of the patients were followed up after three months to confirm the appropriateness of the change in prescribing.

Another example was an audit of patients who had used a blood pressure monitor at home as an aid to the diagnosis of high blood pressure. The results of readings for these patients had enabled clinical staff to reduce their prescribing of medicines for high blood pressure. The audit showed that some patients of working age had declined the use of the ambulatory blood monitoring machine, in case this affected their driving insurance. The practice had recognised this and had suggested a strategy for patients who drove to overcome this barrier to accessing the diagnostic tool. We saw that the outcomes of the audit were circulated to all GPs, nurses and the practice manager.

Patients with long term conditions or regular prescriptions were called in for review systematically or when they requested repeat prescriptions. The administration team operated the recall system and directed patients to an appropriate clinician for their condition. Nurses performed standard checks and any issues were discussed with the GP.

The practice provided care using the 'Gold Standard Framework' (GSF) for people who were approaching the end of their life. The GSF sets standards in end of life care and promotes the involvement of the patient and their family in making decisions about their care for as long as possible. The practice maintained a register of patients who needed end of life care and worked with community

Good

Are services effective?

(for example, treatment is effective)

nurses and Macmillan nurses to ensure those patients' wishes were adhered to and that they received the best possible care. One of the GPs was designated to lead on this area of care. We heard that regular internal and multidisciplinary meetings took place to discuss the care and support needs of patients and their families and that there was effective communication between the practice, a local hospice and a 'hospice at home'. This ensured patient choice and high quality care.

The practice had a lead GP and nurses qualified in diabetes care. They called patients in for review twice each year and told us they took every opportunity to help patients manage their condition. One nurse was the lead for 'insulin starts' which meant that patients with Type Two diabetes could be started on insulin therapy in primary care.

The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, the practice met all the minimum standards for QOF in diabetes care, asthma care and chronic obstructive pulmonary disease (lung disease) care. This practice did not fall outside the expected range for any QOF (or other national) clinical targets. The practice manager told us the practice QOF scores were consistently high and reflected their clinical effectiveness. We saw that their total QOF score was above the score for all practices in England at over 99%.

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

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example in relation to child immunisations.

Effective staffing

The practice team included medical, nursing, managerial, administrative and reception staff. We reviewed staff training records and saw that staff undertook training in relation to their roles and responsibilities.

We noted a good skill mix among the GPs. In particular, one partner GP combined their role in the practice with working as a cardiologist (heart specialist) at the local hospital and had participated in a study of patients with atrial fibrillation. This benefitted patients in that other GPs in the practice could refer their patients who had heart conditions to their colleague and the specialist GP was able to extend their own knowledge and skills and those of their colleagues. The practice was participating in an enhanced service pilot to improve outcomes for patients with heart failure.

Another partner GP was an expert in managing patients who misused substances. They had taken part in a diploma programme in substance misuse through the Royal College of GPs. They worked with other healthcare professionals to provide treatment and support for this group of vulnerable patients.

All the GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation, to ensure they remained fit to practice. 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.

Greyfriars Surgery is a training practice for doctors and two GPs are registered trainers. It provided specialist training places for qualified doctors undertaking GP training as registrars and undergraduate training for medical students. GP registrars were given extended appointments with patients and had access to a senior GP throughout the day for support.

We saw that a nurse practitioner and practice nurses held a range of qualifications appropriate to their roles in the practice. Three of the nurses had diplomas in diabetes care, with one having additional training in starting insulin under the care of the primary medical care team. This enabled patients whose diabetes had progressed to have continuity of care within the practice rather than transfer to hospital care. Three nurses had diplomas in asthma care and two had diplomas in caring for patients with chronic

Good

Are services effective?

(for example, treatment is effective)

obstructive airways disease (COPD), enabling the practice to provide clinics for patients with long term respiratory illnesses. We saw that nurses held other qualifications which included family planning, orthopaedic nursing, leg ulcer management and nurse prescribing.

The training records for administrative and reception staff were not complete but the practice manager told us they had recognised this as an area for improvement and we saw that this was included in the business plan as a task to be completed by the end of March 2015.

Training records confirmed that all staff were up to date with mandatory training such as annual basic life support, infection control and safeguarding. All staff had participated in a training session during their protected time which had focussed on dementia.

We were told that all staff had annual appraisals, conducted by a GP partner for clinical staff or by the practice manager for non-clinical staff and healthcare assistants. We looked at the employment files for a nurse and for a member of the reception team. We found evidence of all relevant recruitment checks; evidence of induction training and annual appraisal. Appraisal included identified learning needs which were reviewed the following year. Our discussions with staff confirmed that they had appraisals and that the practice was proactive in providing training and funding for relevant courses. For example one medical secretary had been supported to attend an advanced level training course; and a member of the administrative team was also completing medical secretary training to ensure the role was always covered.

Working with colleagues and other services

We saw that the practice was committed to the education and development of all staff. There were training schedules for each staff group; an afternoon every three months was designated 'protected time' for training across the practice and the practice team had an 'away day' once each year.

Information from other health providers including test results, hospital discharge summaries and information from the out of hours service came to the practice through the document manager part of the EMIS system. It was processed by the administrative team and directed to an appropriate clinician. EMIS is a computerised system that allows healthcare professionals to record, share and use patient information to help provide better and more efficient care.

In April 2014, in accordance with their annual business plan, the practice had restructured the service it provided to patients who lived in two care homes. A specific GP was nominated to each one and with patient consent, provided care to most of the patients who lived in each home. The practice manager had visited the homes to explain how the service would deliver care and treatment to the patients who lived in the nursing homes.

We read a copy of an email sent to the practice manager by the care home manager which acknowledged how useful it had been to have the face to face contact and how this had been instrumental in establishing positive and effective communication between the home and the practice. The nursing home manager praised the improved continuity of care for their patients; the excellent response to any concerns they had; the high standard of palliative care provided to the patients who needed it; opportunities for patients, their relatives and staff to discuss patients' care needs and the helpfulness of all the staff involved.

The practice manager and GPs told us that until two years ago, health visitors were based in the practice. This had supported positive communication between the staff groups in respect of care planning for vulnerable children. The practice team had recognised that the change to centralised health visitor services could jeopardise the frequency and ease of communication with this team. They had established a programme of regular multi-disciplinary meetings to ensure that information was shared whenever appropriate. The meetings with GPs and the nurse practitioner had extended to include nurses from Hereford's virtual ward, community nurses, Macmillan nurses, midwives and health visitors.

All the GPs saw patients with mental health concerns and referred patients to community or hospital mental health services. A primary care community psychiatric nurse provided a weekly clinic at the practice and a counsellor was available to take referrals. One GP took a special interest in patients whose needs arose from substance misuse. They worked closely with a healthcare worker from DASH, a local service for people with alcohol and substance problems. They provided a 'shared care' methadone clinic for patients in a stable condition who could benefit from this.

A specialist dementia nurse had recently been provided to cover the CCG area and held a clinic at the surgery once

every fortnight. They acted as a link between primary and secondary care and undertook dementia assessments and provided support for families and carers of patients with dementia.

The GPs liaised with community based specialist nurse in respect of patients with diabetes who lived in care homes.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, they used a shared system with the local GP out-of-hours provider which enabled patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals.

Patients' summary care records contained a list of their medical conditions, medication and allergies. In an emergency, the information could be made available to other healthcare providers like hospitals and paramedic services. Patients could choose to opt out of this service and we saw that this was explained in the practice information booklet.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record EMIS to coordinate, document and manage patients' care. All staff were trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records.

Consent to care and treatment

We found that GPs were aware of the Mental Capacity Act 2005 and of 'best interest' decisions. They were able to describe how they followed the law in respect of patients with dementia and patients with a learning disability who might not have the capacity to understand treatment options and make decisions in their own best interests. Patients with a learning disability and those with dementia were supported to be involved in developing care plans which set out their health and social care needs and checked that they were not being harmed or exploited in any way.

The practice maintained a register of their patients with a learning disability and had designated the nurse practitioner as the lead clinician supporting these patients and reviewing their care plans. We saw that the nurse practitioner had developed a template to use in reviews and had completed approximately a quarter of the reviews. Patients had had letters calling them in for the remaining reviews.

All clinical staff we spoke with understood Gillick competencies in respect of children and young people. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes. Patients had not been asked to give written consent.

The GPs told us they were aware of importance of Deprivation Of Liberty Safeguards (DOLs) in respect of patients who had a mental illness. They told us they ensured they acted lawfully to protect patients' rights.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The practice identified patients who needed additional support. Any health concerns were followed up, including offering smoking cessation advice for patients who might benefit from this.

GPs cared for patients who were pregnant and a community midwife held a weekly clinic at the surgery. Health visitor clinics were held centrally, but the practice provided a baby clinic for immunisations. There was a clear policy for following up patients who did not attend.

The practice identified patients who needed additional support, for example patients with complex needs, patients who required end of life care and patients with a learning disability. It was pro-active in offering appointments to those patients. Patients over the age of 75 had access to a named GP, as did patients with complex needs and patients receiving end of life care. We saw that the practice had scored better than the national average in respect of the number of patients with dementia whose care had been reviewed in the previous 15 months.

The practice offered NHS Health Checks to all its patients aged 40 to 75 years and a call and recall system was in

Good

Are services effective?

(for example, treatment is effective)

place. They provided flu vaccinations to vulnerable groups and shingles vaccinations to groups specified in NHS guidance. Private travel vaccinations were available for patients who requested this.

The practice offered contraceptive advice and services, including vasectomy counselling and literature; screening and advice in respect of sexually transmitted infections (STIs) and invited patients for cervical smear testing in line with the national recall system.

The practice followed NICE guidelines in treating and monitoring patients with respiratory illnesses. They told us they were promoting self-management for patients with chronic obstructive airways disease.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with nine patients and two carers. The patients we spoke with told us they were treated with kindness, consideration and respect by all staff. Their dignity and privacy was maintained at all times. They said that the GPs and nurses were supportive and understood their concerns. A disabled patient described how staff helped them to get around the building to ensure they felt safe. The carers we spoke with told us that the patients they cared for were happy with the services provided by the practice and said that as carers they were shown the same level of consideration and respect as patients. Every patient we spoke with was positive about the care they received.

Thirty patients had completed comment cards to tell us about their care. We reviewed their comments and found that patients were positive about the care they received, with some describing their care as excellent. Comments included references to GPs and nurses listening to patients. A temporary patient reported they had received a 'fantastic' service which had alleviated anxiety for them.

We observed how patients were treated by receptionists. We saw that the reception staff were pleasant and welcoming to patients and spoke with them in a discrete manner. The practice manager told us that the reception task was an important one and that staff were highly motivated to provide an excellent service for patients. This was confirmed by other staff we spoke with. The practice manager told us that any concerns about the approach to patients would be discussed in supervisory sessions or team meetings.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the 2013 national patient survey and a survey of patients undertaken by the practice in conjunction with their virtual patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice.

The evidence from a range of sources showed patients were satisfied with the way they were treated by staff. For example, the national data available showed that 82% of patients who used Greyfriars Surgery would recommend the practice to others and that 91% reported a good overall experience of making an appointment. It showed that 95% described the overall experience of their GP surgery as positive. All of these results were higher than the averages for practices across England.

Ninety patients had responded to the practice's annual survey, but not every patient had answered every question. We saw that 85 patients out of 86 respondents would recommend the surgery; 78 out of 82 respondents said they had confidence and trust in the doctor and 73 out of 86 respondents said they were satisfied with their care.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of patients who responded said the GP involved them in care decisions and 88% reported that nurses involved them in care decisions. Both these results were higher than the average for practices across England.

The results from the practice's own satisfaction survey showed that 77 patients out of 82 who responded said that they were involved in making decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them in ways they could understand and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received told us that staff responded compassionately when they needed help and provided support when required. One family carer who was not a patient at the surgery told us how delighted they were to find that their elderly parents received such compassionate care.

Herefordshire has an active support group for carers and we saw that their information leaflet was prominently displayed in different areas of the surgery. Carers told us they were treated kindly by all staff and GPs had ensured they received advice about support networks and about obtaining and collecting prescriptions for the patient they cared for.

GPs told us that when a patient died, the team discussed who would be the most appropriate team member to contact the family to offer bereavement care. Whoever contacted the family would offer a home visit or signpost the family to other sources of support. If a situation arose where the bereaved person lacked capacity to understand events, the team would work in the person's best interests according to the Mental Capacity Act 2005. This might include referring the bereaved person to an advocacy service for support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice understood its patient population and were responsive to their needs. Practice staff engaged with other staff in practices within the Clinical Commissioning Group (CCG) to discuss local needs and work in partnership to meet them. For example GPs working in the Herefordshire CCG had formed a federation to provide extended hours care for their patients. Staff at Greyfriars Surgery could book appointments for their patients with the extended hours service. The federation had recently made a successful bid to provide out of hours care for patients in Herefordshire. We found that the GPs at Greyfriars Surgery were positive about the possibilities of this for their patients.

The practice had a patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The practice manager told us that recently the activity of the group had decreased due to various factors and that they were maintaining contact with the group members through email rather than regular meetings. When the practice completed its most recent patient survey, it did so with support from the 'virtual' PPG.

Tackling inequity and promoting equality

The practice had recognised the needs of different patient groups in the planning of its services. The practice building was an older, listed building, on three levels, including a basement. We saw that patients who used a wheelchair or who were frail or disabled could access the surgery at the basement entrance which was accessible from the care parks. Staff would go down to receive patients and there was a consulting room and a toilet at the lower level so that patients did not have move to any other areas of the practice.

Patients could be supported to access all areas of the practice and we spoke with a patient with a sight impairment who was appreciative of the support provided by members of the reception team. The ground floor waiting area was large enough to accommodate patients with wheelchairs and prams. A waiting area on the first floor was able to accommodate families and babies or children in pushchairs and was accessible by lift. Accessible toilet facilities were available for all patients attending the practice.

People who did not have a permanent address were able to register with the practice care of the practice address.

They told us that approximately three per cent of their patients did not speak English and used a variety of other languages. They used an interpreting service to ensure they were able to communicate with these patients. They were able to pre-book the service or arrange telephone interpreting when the patient needed it.

Access to the service

Appointments were available from 8am to 6pm every week day. The practice remained open through the lunch period. Patients could book appointments by telephone, in person or online. Full information was available to patients about appointments in a practice leaflet and on their website. This included how to arrange urgent appointments and home visits and how to book appointments through the website.

The GPs at Greyfriars Surgery together with other GPs across the Herefordshire CCG area owned and managed the extended hours service. Patients were able to book appointments with this service from the practice. This increased flexibility and choice for all patients.

There were arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were available for people who needed them, including people with long term conditions. Patients over the age of 75 and patients with complex conditions, including patients who received end of life care could request appointments with a named GP or nurse. The practice looked after patients who lived in two local care homes and visited them each week on specified days. A buddy system was in place, so that these visits were not missed.

Although the practice did not offer extended hours appointments, they offered a lunchtime clinic and told us they were flexible in providing appointments early in the morning or late in the day. In this way, they were able to meet the needs of working patients and school age children and young people. Telephone appointments were also available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person, the practice manager, who handled all complaints in the practice. Information about making a complaint was available in the practice leaflet and on the website. The 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.

The practice manager had developed an online system for monitoring complaints and kept a folder for supporting information. This provided a comprehensive view of the complaints and subsequent analysis and actions taken. We saw that all complaints were treated as significant events and were investigated and analysed thoroughly. They were followed up with appropriate actions to prevent recurrence of the issue. Responses to patients or other people who had made complaints were appropriate, informative and timely. Appropriate apologies were made.

The practice team reviewed complaints at a range of meetings: at clinical meetings, at team meetings and at the quarterly 'protected time' learning meetings. We saw that learning points were documented. In April 2014, the learning points included that clinicians should be aware of the impact of including third party information in patient records and that reception staff should encourage patients to provide phone numbers in case appointments needed to be cancelled.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote positive outcomes for patients. We found details of the vision and practice values were part of the practice's annual business plan. We looked at the Business Plan for 2014-15. We saw that a range of objectives had been set, including developing the programme of education and training for all staff; monitoring patient demand for services to plan future services and contingency planning to ensure safe clinical practice and continuity of care. Our inspection took place at the mid-point of the business year and we could see that progress had been made in achieving the objectives.

The business plan also established lead roles and responsibilities, including for palliative care and for safeguarding children and vulnerable adults.

The practice's systematic approach to planning was reflected in high scores on the Quality Outcomes Framework (QOF) which is used by NHS England and local Clinical Commissioning groups to measure the performance of primary medical care practices. The aim to deliver high quality care was reflected too in the discussions about patient care we held with members of the practice team. All the staff we spoke with articulated the same message that they were there to support patients achieve positive health outcomes.

Governance arrangements

Within the practice there was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. The staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice held weekly business and governance meetings. The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at governance, clinical and team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit of the care of patients with coeliac disease made reference to the importance of using accurate codes in patient records to ensure the most appropriate clinical pathways were followed.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues. We saw that the risk log was regularly discussed and updated at team meetings. We saw that all identified risks were assessed and action plans had been produced and implemented. For example, in respect of infection control and staff shortages.

We saw that the practice produced a leaflet about their information governance procedures. The leaflet provided clearly written information for patients about how the practice used their health records and explained their right to confidentiality and their right to access the information held about them.

Leadership, openness and transparency

The GP partners led by example. They were open about their own work and the need to review and challenge their practice. They had developed a learning culture which extended through the practice. There was an emphasis on learning from mistakes, a no blame culture and continuous improvement.

Other staff told us that the GP partners and other managers were very approachable. Staff confirmed that there was an open culture within the practice and that they had opportunities to raise issues at team meetings. They said that they met regularly with their own staff group and that staff training meetings for the whole practice team were held every three months. The records of meetings we reviewed confirmed this.

We saw that the practice produced an information leaflet for patients which clearly described their fees and charges for services which were not covered under their NHS contract, for example travel vaccinations and countersigning documents.

Are services well-led?

Good

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

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

The practice obtained feedback from patients through annual surveys, comments and complaints. They told us they viewed the information as an opportunity to learn and improve their services for patients.

The practice had a patient participation group (PPG). The main aim of a PPG is to ensure that patients are involved in decisions about the range and quality of services provided by the practice. The practice manager told us that recently the activity of the group had decreased due to various factors and that they were maintaining contact with the group members through email rather than regular meetings. When the practice completed its most recent patient survey, it did so with support from the 'virtual' PPG.

The practice gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would discuss any concerns or issues with colleagues and managers. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files relating to staff from different teams and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had protected time for learning every three months.

The practice was a GP training practice which meant that qualified doctors who wished to complete specialist training to become GPs could work at the practice as a registrar under supervision. When patients saw the registrar, they were offered longer appointments and a supervisor was always available for advice when it was needed.