Sarum House 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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Sarum House on 1 October 2014. The inspection team was led by a CQC inspector and included a GP specialist advisor, a practice manage and an Expert by Experience. We found that Sarum House 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 provided to their patients.
- The practice was proactive in helping people 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 with expertise and experience in a wide range of health conditions.

There were areas where the practice needs to make improvements.

The practice should:

- Ensure that all clinicians have an up to date awareness of the Mental Capacity Act 2005 and Gillick competence.
- Introduce a more robust stock control and rotation record for vaccines.
- Consider providing an alarm call in the disabled toilet.
- Carry out Disclosure and Barring Service checks for any non-clinical staff who undertake chaperone duties.

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 safe. 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.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. Patients' care and treatment took account of National Institute for Health and Care Excellence (NICE) and local guidelines. 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 such as asthma and diabetes 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 caring. Data showed patients rated the practice higher than others for several aspects of care. 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.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. 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 are identified. Patients reported good access to the practice and said that urgent appointments were available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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 well-led. 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 developing patient participation group (PPG). 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 people. Patients over the age of 75 had a named GP and 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 people'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 to do these at people's homes if their health prevented them from attending the clinics at the surgery. The practice worked with three local care homes to provide a responsive service to the people who lived there.

People with long term conditions

Good

This practice is rated as good for the care of people with long term conditions. The practice had effective arrangements for making sure that people with long term conditions were invited to the practice for annual and half yearly reviews of their health. Members of the nursing team at the practice ran these clinics and each had an area of specialism such as diabetes or rheumatology.

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

The practice held clinics together with the local specialist diabetes service and hosted a physiotherapist for three days a week to provide ease of access to physiotherapy treatment.

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 ground floor surgery was used to make access easier for families. A midwife came to the practice twice a week to see expectant mothers. Staff told us that ante natal and post natal appointments for mothers were usually done by the female GPs. The practice provided a family planning service.

Summary of findings

Working age people (including those recently retired and students)

Good

This practice is rated as good for the care of working age people, recently retired people and students. The practice provided extended opening hours until 6pm for people unable to visit the practice during the day and also had arrangements for people to have telephone consultations with a GP. They were also able to book evening and weekend appointments for patients with a local GP extended hours 'hub'. The practice was in the process of inviting patients between the ages of 40 and 74 for NHS Health checks. Students were being offered Meningitis C vaccinations before they started at college or university.

People whose circumstances may make them vulnerable

Good

This practice is rated as good for the care of people living in vulnerable circumstances. One of the practice nurses was the lead for learning disability care at the practice and the practice had a learning disability (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 any travelling individuals or families currently registered at the practice. 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.

People experiencing poor mental health (including people with dementia)

Good

This practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice had a register of people at the practice with mental health support and care needs and invited them for half yearly and 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 was alert to the complex needs of people who were living with dementia. They worked with a designated dementia nurse from the local NHS Mental Health Trust with whom they liaised about the care and treatment patients needed.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 17 CQC comment cards patients had filled in and by speaking in person with seven patients, two of whom were involved with the Sarum House 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 with the practice.

Patients were positive about their experience of being patients at Sarum House. 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.

One patient commented that some of the team at the practice took more interest than others although their overall views were also positive. However, several others made remarks about feeling listened to by the GPs and being given the opportunity to ask questions about their care and treatment.

Three patients wrote specific comments about the appointment system. Two confirmed that they were always able to get same day appointments when needed. One patient commented that getting through on the phone was the only thing they felt needed improvement.

Areas for improvement

Action the service SHOULD take to improve

- Ensure that all clinicians have an up to date awareness of the Mental Capacity Act 2005 and Gillick competence. (The 'Gillick Test' helps clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment.)
- Introduce a more robust stock control and rotation record for vaccines.
- Consider providing an alarm call in the disabled toilet.
- Carry out Disclosure and Barring Service checks for any non-clinical staff who undertake chaperone duties.

Sarum House Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a practice manager who is a managing partner at a GP practice.

Background to Sarum House Surgery

Sarum House is in Hereford City Centre and has 11,000 patients. The practice is located in an older building in an historical area of the city. The building has been modernised and extended over the years but due to its location has no further space for development. Hereford serves a mainly white British population with strong agricultural roots with some light industry. There is a substantial eastern European population which dates back to the 1940s and has grown in recent years. The practice has a higher proportion of people over 45 than the England average and in particular, a higher proportion of people over retirement age.

The practice has five partners, three salaried GPs and is a training practice with one GP registrar in post at the time of the inspection. A GP Registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice.

Five of the GPs are female and four are male. The practice has six nurses and one health care assistant. The clinical team are supported by a practice manager, deputy practice manager and a team of reception staff and medical secretaries. Some of the practice team are part time. This provides some inbuilt flexibility for covering annual leave and sickness.

The practice has a General Medical Services (GMS) contract with NHS England. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

This was the first time CQC had inspected the practice. Based on information we gathered as part of our intelligent monitoring systems we had no concerns about the practice. Data we had access to showed that the practice was achieving results that were in line with the England or Clinical Commissioning Group average in most areas.

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

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

Detailed findings

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 1 October 2014. During the inspection we spoke with a range of staff (GPs, nurses, practice managers, reception staff and medical secretaries). We spoke with six patients who used the service, two of whom were members of the Patient Participation Group (PPG).

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)

Good

Are services safe?

Our findings

Safe Track Record

The practice had a system in place for reporting, recording and monitoring significant events, including a detailed policy and procedure which was reviewed in June 2014. Staff had a clear process for recording significant events and the examples we looked at were well documented. The practice was able to provide evidence that they had been recording and monitoring information about safety at the practice for at least seven years.

Staff understood their responsibilities for reporting and recording any incidents or accidents. The practice had a significant event policy and procedure which included a list of the types of things that would need to be reviewed and analysed as a significant event.

Learning and improvement from safety incidents

We saw evidence of significant event analyses (SEAs) and of meetings to discuss actions and decisions made to prevent adverse events happening again. We identified that there was a good flow of information within the practice and a culture of openness and shared learning. The significant event policy stated that one purpose of its policy on reporting was to provide the "safety of a blame free culture". We saw the practice summary of all SEAs during 2014. This included dates when these were discussed by the practice team and references to where the detailed information was kept.

GP practices are required to report certain significant events to CQC. The practice had correctly reported such an event to CQC. This notification provided detailed information about the event and the action staff took.

Reliable safety systems and processes including safeguarding

The practice had well organised and clearly documented records to show that all the necessary checks, including Disclosure and Barring Service checks (DBS) were made when clinical staff were employed to work at the practice. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. The practice had not routinely carried out DBS checks for non-clinical staff. This was based on a risk assessment that these staff were rarely on their own with people who may be vulnerable, even when they did chaperone duties. However, the practice manager told us that they planned to review this because they recognised that it would be best practice to carry out DBS checks for staff who carry out chaperone duties.

The practice had a chaperoning policy and provided training for those non-clinical staff who were asked to fulfil this role when needed. Staff we spoke with confirmed they had been trained for this role and showed that they understood their responsibilities regarding this. Information about the availability of chaperones was available on the practice website but could have been more prominently displayed within the practice. However, staff told us that people were always offered the opportunity to have a chaperone at the start of any appointment involving a sensitive examination. Staff told us that a note was made in patient records when a chaperone was present to provide an audit trail.

The practice had a clear safeguarding policy which included information about the processes involved and important contact numbers for the multi-disciplinary child and adult safeguarding teams. There was also an internal reporting process. We saw comprehensive information to help staff recognise child abuse and understand responsibilities. The information about child safeguarding was more developed than that about adult safeguarding. The practice acknowledged this and said they would extend the details for adults to a similar degree. All of the staff we spoke with knew who the practice's safeguarding lead was and were clear about their duty to report abuse and neglect.

Multi agency safeguarding hubs (MASH) provide structures for all agencies with safeguarding responsibilities to communicate and work together effectively. We found evidence of good communication between Sarum House and the Herefordshire MASH and of six weekly meetings with Health Visitors to discuss child safeguarding cases. The practice was proactive in identifying and informing their partners of any new safeguarding concerns.

The practice kept a spreadsheet to monitor any child safeguarding cases known to the practice. We saw that this was regularly updated to keep information current; this included information and actions arising from practice meetings with MASH partners. The practice had clear systems which made sure that relevant staff were aware of any child known to be at risk. Individual patient records

were noted when the practice was aware of adult safeguarding concerns. The practice also maintained a list of cases they were made aware of by other agencies such as the local authority adult safeguarding team.

GPs, nurses and other staff had done e-learning safeguarding training and some had attended a combined course about safeguarding and the Mental Capacity Act 2005 (MCA) delivered by the Clinical Commissioning Group (CCG) safeguarding lead in 2013. CCGs are NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in England. Staff we spoke to all knew which GP was the safeguarding lead. We saw certificates confirming that the safeguarding lead had done training at the appropriate level for the role. Staff we spoke with had a good understanding of their roles and responsibilities regarding safeguarding.

There was a whistleblowing policy. We noted that this did not specifically refer to the relevant legislation, the Public Interest Disclosure Act 1998 or set out the protection employees have under this legislation if they raise concerns in a suitable way as described in the Act. However, staff confirmed that they would record any incident of whistleblowing as a significant event and speak with the practice manager and the GP safeguarding lead. They were confident that action would be taken and that a significant event analysis would be done. We learned that all staff at the practice had access to reporting forms on the practice computer system and could complete and submit forms on their own initiative. A partner gave us an example of how the partners had reviewed some issues raised in this way and taken steps to resolve a concern. The example showed a transparent and constructive approach to concerns raised by staff.

The basement in the building was used for storage; this included storage for patient records. A group of about 80 patients had joined the practice eight weeks earlier when changes were made locally to the allocation of patients in care homes to GP practices in the city. We saw that records for these patients were waiting to be summarised. These had not been organised so that a specific record could be found quickly if it was needed. We highlighted this with the practice manager who put this right the following day by getting the records filed alphabetically. They sent us photographic evidence of this. The practice confirmed that key medical information about those patients was also available in the care homes.

Medicines Management

The practice had a lead GP for the repeat prescribing arrangements and policy. The policy had been reviewed in November 2013.

The prescribing arrangements at the practice gave patients a variety of options for obtaining their repeat prescriptions. There was a process for prompting patients who needed to have their medicines reviewed by a GP and this was done at suitable intervals depending on the specific requirements relating to individual medicines. Prescribing patterns for some medicines had been monitored as part of a full clinical audit cycle looking at side effects for patients.

We saw evidence that the practice had carried out a significant event analysis in respect of a concern about a person's medicine. This showed that issues were identified and acted on openly.

The practice held monthly clinical forum meetings. These included discussions of prescribing in comparison with other local practices, particularly in respect of antibiotic prescribing rates.

When GPs visited patients at home they generally did electronic prescriptions on their return to the practice which the patient or someone they asked could then collect from a pharmacy. The practice did have paper prescription pads as well. These were securely stored and the practice kept a log to record the name of the GP who had taken them along with the dates. The practice manager intended to make their audit trail for prescriptions more robust in line with NHS guidance.

One nurse was responsible for ordering the vaccines for baby immunisations. Stocks were checked at the end of each clinic before new stock was ordered. This helped to minimise waste by over ordering. The batch number and expiry date of vaccines were recorded in the notes for the child they were used for. This ensured traceability. The practice did not have structured stock control or rotation records to create a readily accessible audit trail. However, with the nurse we randomly checked 10 items from the fridge and these were all well inside their expiry dates. We saw evidence that the vaccine fridge temperatures were monitored and recorded each day.

Cleanliness & Infection Control

Good

Are services safe?

Some patients specifically commented on the high standard of hygiene and cleanliness at the practice. The practice was clean and tidy when we inspected. The Clinical Commissioning Group (CCG) lead nurse for infection prevention and control (IPC) had carried out an IPC audit at the practice in 2013. The practice score for this audit was 96%. They made some recommendations for action and the practice provided us with information about the action they had taken. The practice had asked one of the nurses to become the practice lead for IPC and they had recently asked the CCG lead nurse to come back and carry out another audit.

We saw that there were no products available in the baby change area for cleaning the baby change table when it had been used. This had been identified in the 2013 IPC audit. The practice had acted on advice given by the IPC lead nurse to put up a sign asking for the area to be cleaned after use. We noted that the sign stated that wipes were available from reception on request. We pointed out that it was possible not to notice the sign because of where it was displayed. The practice said they would move this so that it was more prominent.

The practice had an up to date legionella risk assessment which had established that the building had low levels of risk in relation to legionella bacteria.

There were cleaning schedules in place and dates for washing or replacing privacy curtains around examination couches were recorded in the reception diary and on the curtains themselves. There was locked storage for clinical waste and 'sharps' awaiting collection. The practice had a contract with a specialist company for the collection of these.

Equipment

We established that the practice had the equipment they needed for the care and treatment they provided and that this was maintained and re-calibrated as required. However, we noted that there was no alarm system in the disabled toilet for a patient to summon help if they needed to.

Staffing & Recruitment

The overall staffing levels and skill mix at the practice ensured that sufficient staff were available to maintain a safe level of service to patients without working excessive hours. The practice had one full time equivalent GP for every 2033 patients registered with the practice and were providing a sufficient number of appointments for the total number of patients on their list.

The partner, salaried GPs and nurses at Sarum House provided a broad mix of specialist areas of knowledge and skills. The specialisms of the clinical team included dermatology, cardiology, diabetes chronic obstructive pulmonary disease and cancer. A GP at the practice is the lead GP for cancer within the Clinical Commissioning Group (CCG).

There was a strong nursing team at Sarum House. This consisted of two Nurse Practitioners, four Practice Nurses and a Health Care Assistant /Phlebotomist.

Staff we spoke with and information we were shown confirmed that the GPs provided additional cover for each other when any of them were unexpectedly unavailable at short notice. The practice did not use agency locums. If they were unable to cover GP sessions in house they used other local GPs that they knew well, often because they had worked at the practice before.

Monitoring Safety & Responding to Risk

The practice had robust arrangements for identifying those patients who may be at risk for whatever reason. There were practice registers in place for people in high risk groups such as those with long term conditions, mental health needs, dementia or learning disabilities. The practice included people in those groups in their 'preventing unplanned admissions' patient register. The practice computer system was set up to alert GPs and nurses to patients in these groups and to adults and children who may be at risk due to abuse or neglect.

All staff at the practice had completed cardiopulmonary resuscitation training. The practice had a defibrillator, oxygen and emergency drugs available for use in medical emergencies. The practice computer system included an instant messaging alert system. Staff explained that they could use this in the event of a medical emergency in the building to send a message to GPs and nurses asking for urgent assistance. We saw a significant event analysis about an occasion the practice had needed to use their emergency procedures. This showed that staff had responded quickly and had worked well together as a team.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

We learned that in the event of a major incident resulting in the practice not being able to open, practices within Hereford city provided 'buddy' cover for other practices.

We saw that the practice had a comprehensive continuity plan which staff were aware of and understood. The practice manager and partners all had a copy of this which they kept off site so they could be sure they had access to this in an emergency.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Our discussions with GPs provided confirmation that they were aware of and worked to National Institute for Health and Care Excellence (NICE) guidelines about best practice in care and treatment. This was supported by the high achievement levels the practice had for the Quality and Outcomes Framework or QOF. QOF is a scheme which rewards practices for providing quality care and helps to fund further improvements. Staff told us that the practice shared information about current best practice through their own clinical forum meetings and by taking part in a monthly 'Journal Club' with GPs from other local practices. We saw minutes of clinical forum meetings showing that these included discussions about NICE guidance and any action that the practice needed to take in response to these.

Management, monitoring and improving outcomes for people

Members of the team described a proactive approach to making sure that people with long term conditions were reviewed regularly. The practice held Systematic Monitoring and Review of Conditions (SMART) clinics for people with long term health conditions. These were used to make sure patients were invited to the practice for annual and half yearly reviews of their health. Members of the nursing team at the practice ran these clinics and each had an area of specialism such as diabetes or rheumatology.

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

The practice was actively working towards reducing the number of unplanned admissions for patients and had a register of patients who may be at risk due to factors such as age or a long term health conditions.

The practice held clinics together with the local specialist diabetes service and employed a physiotherapist for three days a week to provide ease of access to physiotherapy treatment. People with Chronic Obstructive Pulmonary Disease (COPD) were provided with resource packs with information to help them manage their condition.

The practice held monthly and twice monthly meetings during which care and treatment of specific patients was discussed as well as more general topics. As part of this the practice had recently added a slot to discuss patients newly diagnosed with cancer.

The practice had a system in place for completing clinical audit cycles, a process by which practices can demonstrate ongoing quality improvement and effective care. Examples of completed clinical audits the practice had done included, measurement of vitamin B12 levels in people taking Metformin, termination of pregnancy, use of Strontium for patients with Osteoporosis, use of long acting reversible contraception (LARC) and gestational diabetes. The clinical audit information for LARC showed that the practice had been monitoring uptake the practice since 2006 following NICE guidance in 2005. The information we saw showed that during that time the practice had seen an increase in uptake of this type of contraception and a decrease in the number of pregnancy terminations.

Effective staffing

The GPs and nurses at the practice had a wide range of knowledge and skills. They described using their individual and combined clinical expertise to make sure patients benefitted, for example by referring patients to colleagues within the practice with specialist knowledge about particular health conditions. The clinicians' knowledge and skill was updated with ongoing accredited training and in-house training.

The administrative and reception team had a number of new members of staff. Staff told us that there were enough of them to do the work and that the practice had invested time in making sure that the staff members had the necessary training. The practice had a 'buddy' system for new staff. One of the reception staff explained to us that they had worked alongside their 'buddy' for their first three months. They felt happy that they had been well supported during this period so that they fully understood how things worked and what their role was. The GP registrar felt well supported and confirmed that they had an induction

Good

Are services effective?

(for example, treatment is effective)

programme when they started and had been given time to settle in. A GP Registrar or GP trainee is a qualified doctor who is training to become a GP through a period of working and training in a practice.

The practice had a positive and supportive approach to managing concerns about staff performance. The practice manager recognised the value of reacting quickly to problems and dealing with matters at an early stage. The practice investigated any issues with the benefit of specialist employment advice and made sure that affected staff were offered suitable support.

Staff confirmed that they received regular supervision and an annual appraisal. They felt they were supported and encouraged to develop their skills and learning. The salaried GPs and nurses were provided with specified amounts of paid time to use for their continued professional development (CPD). The practice kept comprehensive staff training records which we sampled for evidence of staff training, professional recertification in specialist areas and GP revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHE England can the GP continue to practice and remain on the performers list with the General Medical Council.) The practice had a detailed study and training leave policy which was reviewed in March 2014. This was supported by a detailed protocol showing the mandatory and recommended training the practice required each group of staff to do. This included the frequency for this and the regulatory body or legislation relevant to the training topic.

Working with colleagues and other services

GPs told us that each morning they discussed patient referrals within the practice as a way of sharing information. The practice had introduced a digital dictation system which GPs and medical secretaries told us they had found to be a more efficient and effective means of making sure referral letters were sent to other services as quickly as possible. We were shown that the system was used to prioritise the secretaries' work so they could make sure that they sent referral letters in the right order. Patients with an urgent need to be seen were given a leaflet with telephone details for the service they were referred to so that they could make direct contact.

GPs described to us the ways they would discuss a patient's options with them so that they could make the most suitable referral decisions.

The practice described working in partnership with other services such as Macmillan nurses, district nurses and the local hospice. They recognised the importance and value of this, particularly for patients with long term conditions or needing end of life or palliative care. The practice had a palliative care lead who led monthly meetings to discuss patients receiving palliative care and to make sure up to date information was available and shared with other services including the out of hours service.

The practice provided a number of clinics run by professionals employed by other NHS organisations such as the local NHS community and mental health trusts. These provided people with access to specialist mental health and dementia services, physiotherapy, counselling services and ante natal and post natal care. A GP described the importance of co-ordinating care of patients with complex needs not only with other professionals but also with family members. They recognised the need to consider patients' social needs alongside their medical needs.

Hereford County Hospital operates a 'virtual ward' scheme to help reduce hospital admissions and re-admissions. The practice supported this scheme which enabled them to keep their patients at home or enabled them to return home sooner after being in hospital.

In addition to the learning and development they did within the practice the GPs also participated in a monthly 'Journal Club' with other practices in the city to encourage and develop more opportunities for support and shared learning.

Information Sharing

There was a system for making sure test results and other important communications about patients were dealt with. Each GP was allocated their absent colleague's incoming information alphabetically. This meant that all results were seen and there was clarity about which GP was responsible for dealing with them.

The practice had systems for making information available to the 'out of hours' service about patients with complex care needs, such as those receiving end of life care.

Good

Are services effective?

(for example, treatment is effective)

All members of staff had done training about information governance to help ensure that information at the practice was dealt with safely with regard to people's rights as to how their information was gather, used and shared. An in-house messaging system was used for sharing information internally. This provided a clear audit trail for internal messages between members of the team. Staff were alert to the importance of only sharing information with patients or with patients' consent and gave us an example of a situation where a receptionist had checked a request with a GP.

Consent to care and treatment

The practice had a written protocol for consent which was added to the practice website following our inspection to make it readily available to patients. This referred to situations where people lacked capacity to make some decisions through illness or disability. In these circumstances health and care providers must work within the Code of Practice for the Mental Capacity Act 2005 (MCA) to ensure that decisions about care and treatment are made in people's best interests. The protocol did not explicitly mention the MCA but covered some of the most important aspects of the legislation including best interest decisions and independent mental capacity advocates. The protocol also described the issues to consider when making decisions about the ability of children and young people to give consent on their own behalf, specifically Gillick Competence and Fraser guidelines.

Clinical staff we spoke with were aware of their responsibilities in respect of consent and described the ways in which they would check whether people had capacity to make decisions. Some staff had attended training about the MCA in 2013 while others had read about the requirements of the Act but not done structured training. This meant that some lacked confidence in describing the three stages of a mental capacity assessment. The practice manager told us they recognised this was an area where they needed to update staff training. They were identifying suitable training resources for this. They told us that this would be included as a topic for the practice's next training afternoon.

GPs and nurses with duties involving children and young people under 16 were aware of the need to consider Gillick competence and to act in line with Fraser guidelines regarding the provision of contraception.

Health Promotion & Prevention

There was a wide range of information leaflets, booklets and posters about health, social care and other helpful topics in the waiting room, reception and entrance hall where patients could see them. These included information about Healthwatch, Age Concern, safeguarding, cancer care, multiple sclerosis and drug and alcohol services.

The practice had a rolling programme for patients between 40 and 74 years of age to invite them for NHS health screening checks and provided a cervical screening programme. Patients were being sent leaflets and letters about this explaining what the check would involve. They could book appointments online, in person or by phone. Clinics for childhood immunisations were held and six week checks were carried out for babies. Data we looked at before the inspection showed that the practice was broadly in line with other practices in the area for take up of childhood immunisations. NHS England data held by the practice for the quarter immediately before the inspection showed that the practice was meeting expected immunisation levels for the current year.

The practice had arranged two Saturday morning 'flu vaccination clinics during October. These were advertised in the practice, in their newsletter and on the practice website. Shingles vaccinations were available for people aged 70 or 79.

There was support for people wanting to stop smoking in the form of leaflets and smoking cessation appointments with a health care assistant trained for this role. The practice was also able to refer patients to a local council's 'Healthy Lifestyle Trainer Service' and 'Lifestyle Improvements for Today' (LIFT) services. These provided diet and exercise guidance and support for patients who needed to develop a healthier lifestyle.

The practice did not routinely carry out health checks when new patients joined the practice. New patients were asked to fill in a questionnaire about their health history. This was reviewed alongside their medical records from their previous GPs. People with long term conditions were called in for an appointment and added to the practice's SMART clinic list. New patients without a specific health need could ask for an appointment if they wished.

The practice had recently introduced a practice newsletter as a way to provide patients with information about health

Good

Are services effective?

(for example, treatment is effective)

initiatives such as 'flu clinics, shingles vaccines, named GPs for people over 70, health checks and staying safe in the sun. The newsletter also provided updates about changes in practice staff and the Patient Participation Group (PPG).

A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We gathered the views of patients from the practice by looking at the 17 CQC comment cards that patients had filled in and spoke in person with seven patients, two of whom were involved with the Patient Participation Group (PPG). A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. Many patients who gave us their views had been patients at the practice for many years and their comments reflected this long term experience.

The information we gained from this showed that patients had positive views about the approach of staff. Patients told us that they were treated with respect and that members of the staff team at Sarum House were kind, sensitive and helpful. Several expressed appreciation for the service they had received. In one of the comment cards a patient commented that some staff were more caring than others. One other person had written that they felt frustrated by the approach being taken to their care needs.

During the inspection we spent time in the waiting room and reception. This gave us the chance to see and hear how staff dealt with patients. We observed that there was a friendly atmosphere and that the reception staff were polite and pleasant to patients. We had been told by the GPs that they went to the waiting room to ask people through for their appointments because this was more friendly and personal. We saw this happening throughout the inspection.

The practice had a consent and confidentiality policy. Any information about consent provided by patients was kept in patients' records. The reception desk was at a high level which meant that patients were unable to look over and see information on computer screens or desk. The practice manager told us that when patients in wheelchairs came to reception staff took their cue from the person and would often go around to the front of the desk rather than speaking over the top of it. Patients wanting to speak privately to a receptionist were offered the opportunity to be seen in another room.

Staff told us that care was taken when speaking to people about things such as test results to make sure patients' confidentiality was protected. Reception staff did not generally give out results and when they did this was only directly to the patient concerned or to someone else with the patient's written consent.

Care planning and involvement in decisions about care and treatment

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 that 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. A minority gave us examples where they felt they had not been listened to as they would have liked.

A parent we spoke with told us they were kept well informed about their child's health.

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 offer the opportunity to speak with a member of the team. Information was provided about organisations specialising in providing bereavement support.

Staff told us that they had a carers' lead as recommended by Herefordshire Carer Support (HCS), an organisation that provides support and guidance to carers in Herefordshire. This was one of the reception staff. We saw information displayed about HCS and several staff said they worked closely with them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice made arrangements for people with restricted mobility to be seen in one of the ground floor surgeries. We saw this happen on the day of the inspection and noted that the GPs worked co-operatively to facilitate this. The practice did not have an induction loop to assist patients who used hearing aids. This was due to constraints of the building. However the practice manager told us the practice would obtain a portable version.

The practice had a register of people at the practice with mental health support and care needs. Each person on the register was invited for an annual (and often also for a six month) review. Staff explained that they had good working relationships with the local mental health team which was based in the same street. A mental health worker was at the practice two days a week to support the team to identify patients' needs and to provide patients with counselling, support and information. Patients were able to refer themselves to see this person as well as GPs making referrals for people they believed would benefit.

The team were alert to the complex needs of people who were living with dementia and had a dementia register. They had links with the team in the local department of health for older people and with a designated dementia worker who they were able to make referrals to and liaise with about care and treatment. We spoke with the managers of three local care homes where many of the people had care needs due to dementia. They told us that the GP from Sarum House involved patients in discussions about their health as much as possible and was respectful and caring.

The practice provided general practice cover to approximately 80 people living in three care homes in Hereford. This reflected an arrangement between the CCG and GP practices in Hereford city to provide a more responsive service to older people living in care homes in the city. The practice told us that patients who did not wish to transfer to the practice which covered the care home they were moving to could remain registered with Sarum House and they would still provide their GP care.

We spoke with the managers of these care homes about the service people received from Sarum House. All three were positive about the service. They told us that a GP did a routine weekly visit to the home as well as visits on other days as needed. All three managers said that it was usually the same GP who visited and that this provided welcome continuity. The arrangement was fairly new and had taken a while to settle down but each home said the arrangements were working well. They told us that the GP was polite, respectful and kind to their patients and listened to them. All three managers confirmed that the GP was working with them to review each person's medicines. The practice manager told us that the reviews of medicines would shortly involve a pharmacist from the CCG who the practice was working with.

One care home manager gave us an example of the GP identifying the cause of a patient's unexplained health concern. The person was able to be treated accordingly and their health improved.

Tackling inequity and promoting equality

Staff told us that the practice was supportive to homeless people who came to the practice to be seen. As an example of this one of the staff explained that they would offer support in identifying an address which people could use for correspondence. However, a GP told us that in general homeless people in the city were more likely to go to the GP walk-in centre in the city.

Reception staff offered to show us and explain the telephone interpreting service they used for patients who are unable to converse with ease in English. The system was easy to use and accessible and the member of 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. A hard wired system had previously been investigated and the practice had established that it would be difficult to install in the building. The practice had not been aware that a portable induction loop system which can be taken to whichever room it is needed in was now available.

Access to the service

The information from CQC comment cards and patients we spoke with indicated that the service was generally

Good

Are services responsive to people's needs?

(for example, to feedback?)

accessible and that patients were able to get an appointment on the same day they phoned if this was needed. Two patients mentioned how busy the telephone could be in the morning. One of these added that they appreciated the reasons for this.

The practice provided routine appointments for patients three working days in the future. There was a telephone duty doctor system. This provided patients with the opportunity to speak with the duty GP throughout the day so that the urgency of their health concern could be assessed. Patients were given an appointment with the duty GP the same day if needed. This meant they were seen by the doctor they had already spoken with which provided consistency.

The practice recognised that there was often a 'bottleneck' for patients phoning the practice, particularly at peak times such as first thing on a Monday morning. The practice had not carried out an audit to analyse the volume and types of calls. They agreed that doing this would give them objective information and help them to make informed decisions on a strategy to improve telephone access.

Patients who wanted an appointment later in the evening than 6pm or at weekends were told about a local extended hours initiative by a federation of local GPs. This provided appointments between 6.30 and 8pm on weekdays and between 8am and 8pm at weekends. Receptionists at all GP practices locally have access to the appointment booking system and can book appointments direct for patients. Telephone consultations were also available so that patients could speak with a GP without always needing to have an appointment at the practice.

Listening and learning from concerns & complaints

The practice had a system for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England. We saw a copy of a training presentation for staff about complaints. The presentation focussed on learning from complaints received during 2013. It reflected on some of the complaints the practice had received and considered the management of complaints and concerns in general. It looked at the range of reasons why people make complaints and how and why staff in organisations react to these. This showed an open and transparent desire to make sure the practice used complaints not only to improve the service but also to develop staff awareness and skill when they had to deal with complaints.

We saw that the practice had written promptly to people who had complained. The responses we saw were well written and provided people with appropriate information including apologies where this was judged necessary. We saw documentary evidence of internal clinical team meetings to discuss complaints made to the practice. We saw that the meetings were used to review cases and consider how complaints should be dealt with, including the content of responses to people who had complained. Most complaints had been completed and closed in house but one had been referred to the Parliamentary and Health Service Ombudsman.

The practice had a complaints leaflet which included information about independent advocacy services which could provide patients with support in respect of making a complaint if they needed or wanted this. There was a comments box just inside the main entrance to the practice. There was no pen or paper available to use if someone needed this. We highlighted to the practice that a person wanting to make a comment might prefer not to have to ask for these. We also highlighted that in its current position, patients may walk past the box without registering that it was there.

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

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 fortnightly partners' meetings to discuss important issues such as forward planning, practice objectives and staff morale.

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. One of the partners was the lead for 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 monthly clinical forum and monthly 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 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 demonstrating that the practice was reviewing and evaluating the care and treatment patients received.

Leadership, openness and transparency

The practice had a longstanding team of partners who 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 Sarum House 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 established a Patient Participation Group (PPG) six months before our inspection. A PPG is usually made up of a group of patient volunteers and members of a GP practice team. The purpose of a PPG is to discuss the services offered and how improvements can be made to benefit the practice and its patients. At the time of the inspection the PPG had 11 members with roughly equal membership of men and women. This had initially been run as a 'virtual' group with communication mainly by email. Information about the PPG and how to get involved was included on the practice website. The practice had recently arranged a face to face meeting of the PPG which was attended by eight patients, the practice manager and all of the partners.

We spoke with two patients who were members of the PPG. One explained that the first meeting was held during the day which meant that people with day time commitments were not able to take part. They told us that the practice took note of this and have booked the next meeting for an evening. The patients we spoke with and the team at the practice recognised the potential benefits of well-established PPG. The practice manager told us that following the well-received first meeting they hoped that the PPG would continue to develop. PPG members had indicated that two meetings a year was a good starting point and the intention was to alternate day time and evening meetings to meet the needs of as many of the members as possible. The practice had uploaded minutes from the first meeting to the PPG area of the practice website.

During September 2013 the PPG had worked with the practice to distribute 300 patient surveys, this represented 2.73% of the practice population. The results from 259 completed surveys showed an overall patient satisfaction rate of 85% in the good, very good or excellent range. The practice did more consultations using online surveys. One of these asked patients about telephone access. The responses showed that people found it difficult to get through on the phone so the practice was looking at making improvements, including having additional telephone lines. Other developments at the practice made

Are services well-led?

Good

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

at least in part as a result of patient consultation were provision of access to the Hereford extended hours 'hub' and extension of access to online services such as appointment bookings and ordering repeat prescriptions.

Staff recognised the value of sharing information about positive feedback from patients. The internal messaging system was used to make sure people were given feedback promptly.

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 a half day once each quarter for 'protected learning'. This was used for training and to give staff the opportunity to send time together. Cover for the practice was provided by another practice during this time.

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

The practice is a training practice providing GP training places for up to two GP Registrars. Only approved training practices can employ GP Registrars and the practice must have at least one approved GP trainer. A GP Registrar is a qualified doctor who is training to become a GP through a period of working and training in a practice. We spoke with the practice's current GP Registrar. They confirmed that they had a named GP trainer at the practice and felt well supported by the whole team. They confirmed that they had an induction and "settling in" period when they first arrived.