

# The Mortimer Medical Practice

## 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 inspected this practice on 16 October 2014 as part of our new comprehensive inspection programme.

The practice operates from three sites in Herefordshire, a main surgery in Kingsland and two branch surgeries, one in Orleton and one in Leintwardine. The two branch surgeries are included in the main practice's CQC registration. We did not inspect the two branch surgeries during our inspection.

The overall rating for this practice is good. We found the practice was good in the safe, effective caring, responsive and well-led responsive domains. We found the practice provided good care to older people, people with long term conditions, people in vulnerable circumstances, families, children and young people, working age people and people experiencing poor mental health.

Our key findings were as follows:

- Patients were satisfied with how they were treated and that this was with compassion, dignity and respect. They felt the GPs listened to them and gave them enough time.
- Patients were kept safe because there were arrangements in place for staff to report and learn from key safety risks. The practice had a system in place for reporting, recording and monitoring significant events over time.
- There were systems in place to keep patients safe from the risk and spread of infection.
- The practice was responsive to the differing needs of its patient population and planned its services to meet these needs.

During our inspection we did not identify any areas where the practice was required to make improvements

**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?

The practice is rated as good for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. There were robust systems in place to protect children and vulnerable adults from the risk of abuse. Information about safety was recorded, monitored, appropriately reviewed and addressed. There were systems in place to keep patients safe from the risk and spread of infection. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Good



### Are services effective?

The practice is rated as good for effective. National Institute for Health and Care Excellence (NICE) guidance was referenced and used routinely. People's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity and the promotion of good health. Staff had received training appropriate to their roles and further training needs had been identified and planned through regular appraisals. Multidisciplinary working was evidenced.

Good



### Are services caring?

The practice is rated as good for caring. Data showed 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 care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Good



### Are services responsive to people's needs?

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG). Both of these organisations commission healthcare locally. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff.

Good



# Summary of findings

## Are services well-led?

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. 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 regular governance meetings had taken place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Good



# 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

The practice is rated as good for the care of older people. Nationally reported data showed the practice had good outcomes for conditions commonly found among older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. The practice was responsive to the needs of older people, including offering home visits, including to patients in five local care homes.

Good



### People with long term conditions

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place for patients in this group that had a sudden deterioration in health. Longer appointments and home visits were available when needed. These patients had a named GP and structured reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Good



### Families, children and young people

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. Immunisation rates were relatively high for most standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives and health visitors. Emergency processes were in place for children and pregnant women who had a sudden deterioration in health.

Good



### Working age people (including those recently retired and students)

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

Good



# Summary of findings

## People whose circumstances may make them vulnerable

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including travellers and those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities. The practice offered longer appointments for people with learning disabilities.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. 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 and out of hours.

Good



## People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). People experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia.

The practice had sign-posted patients experiencing poor mental health, including people with dementia, to various support groups and third sector organisations. Staff had received training on how to care for people with mental health needs.

Good



# Summary of findings

## What people who use the service say

We spoke with eight patients on the day of our inspection. We also looked at six cards from a comments box which had been placed in the practice for up to two weeks before we inspected. The comments we received from patients were positive and reflected their satisfaction with the service they received. They told us staff at all levels were friendly and helpful, that they were treated with respect and that their dignity was protected.

They said they did not feel rushed during their consultations and that us staff listened to them and took time to explain what was happening. Patients said they found the appointments system met their needs and was easy to use. They said the process for obtaining prescriptions and repeat prescriptions worked well and felt the practice was well-run.

# The Mortimer Medical Practice

## Detailed findings

### Our inspection team

#### Our inspection team was led by:

Keith Briant

## Background to The Mortimer Medical Practice

The Mortimer Medical Practice provides primary medical services from a main surgery, Croase Orchard at Kingsland in Herefordshire and two branch surgeries in Orleton and Leintwardine. Dispensing services are provided at all three surgery sites. The practice has a registered list of approximately 7800 patients spread over a largely rural area of around 200 square miles. Approximately 20% of the practice's patients are over the age of 65.

The practice team working across the three sites consists of six GP partners, two salaried GPs and a medical student, supported by five practice nurses, a practice manager, six dedicated dispensing staff and two healthcare assistants. In addition there is a team of 14 administrative and reception staff as well as a housekeeper and a small team of external support staff, including a midwife, a physiotherapist, a community psychiatric nurse and a healthcare visitor. The practice nurses and healthcare assistants are all female, while the GPs are split 50% male and female, which provides patients with a choice of the gender of the GP they would prefer to see. The practice is a training practice for medical students in their third and fifth year of their studies at Keele University.

We did not identify any concerns with the branch surgeries during our pre-inspection preparation and did not visit them as part of our inspection. Our preparation included discussions with the NHS England Local Area Team (LAT) and the Clinical Commissioning Group (CCG). Both of these organisations commission healthcare services in the area.

The practice does not provide an out-of-hours service but they have alternative arrangements for patients to be seen when the practice is closed.

## 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.

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

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)

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations such as the local clinical commissioning group (CCG), the NHS England Local Area Team and the local Healthwatch to share what they knew. The CCG and NHS England are both commissioners of local healthcare services. We also spoke with a representative of the area Local Medical Committee who gave us information about the health economy in the area. We carried out an announced inspection on 16 October 2014. During our inspection we spoke with a range of staff including a GP, the practice manager, a practice nurse, a healthcare assistant, two dispensing staff, three administrative staff and a receptionist. We also spoke with patients who used the service. We observed how people were being cared for and talked with carers and family members. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

# Are services safe?

## Our findings

### Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. We saw examples of this which included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, we saw how the practice had made changes to their procedure for transferring information about patients' medicines from hospital discharge letters into their patient notes after an error had occurred previously.

We reviewed safety records and incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

### Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred during the last seven years and these were made available to us. We saw that significant events were included on the agenda for practice meetings and actions resulting from past significant events and complaints were reviewed on a quarterly basis.

We saw staff had access to incident forms. Once completed these were sent to the practice manager who showed us the system she used to ensure these were managed and monitored. We tracked five incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, one patient had not been able to book an appointment to have specific blood tests done on the day they were needed. An analysis of the incident showed that appointments for this purpose had been available on the day they were required and that the issue lay with record keeping and patient communication. As a result the system for contacting patients about these blood tests and the recording system were revised to minimise the risk of this type of incident recurring. Action was also taken to remind non-clinical staff of the importance of carrying out these blood tests at the correct time.

### Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records showed that all staff had received training in safeguarding which was relevant to their role. Staff we spoke with at all levels knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Contact details were easily accessible and staff knew where to find them. The practice had a chaperone policy in place and chaperone training had been undertaken by all relevant staff. Information about the chaperoning service was contained in the practice's information leaflet.

We saw that the practice had carried out criminal record checks on all clinical staff and some non-clinical staff to ensure they were suitable to work with children and vulnerable adults. Risk assessments had not been carried out for members of reception staff whose criminal records had not been checked. We raised this with the practice manager, who took immediate steps to ensure this was carried out.

The practice had a dedicated GP appointed to lead in safeguarding vulnerable adults and children who had been trained to enable them to fulfil this role. All staff we spoke with were aware who this lead was and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information so staff were aware of any relevant issues when patients attended appointments.

### 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 medicines were kept at the required temperatures. This was being followed by the practice staff, who were able to describe the action to take in the event of a potential failure.

## Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. A system was in place to dispose of expired and unwanted medicines in line with waste regulations.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. We saw up to date copies of these directions and evidence that the nurses had received appropriate training to administer vaccines.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas, including how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. The practice used an electronic dispensing system which automatically checked the review date of patients' repeat prescriptions and produced a prompt for the patient to see the GP if the review date was due. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

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.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. We found two examples of controlled drugs that had passed their expiry date. These drugs had been intended for destruction but had been included in the main stock count in error. We checked records which showed that neither of these drugs had been dispensed to a patient in over 12 months. The practice took immediate steps to separate the expired drugs from the main stock. All the other medicines we checked at the practice were within their expiry dates.

Dispensing staff at the practice were aware prescriptions should be signed before being dispensed. We saw records showing all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

The practice had established a service for people to pick up their dispensed prescriptions at three additional locations and had systems in place to monitor how these medicines were collected.

### Cleanliness & Infection Control

There were systems in place to keep patients safe from the risk and spread of infection.

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and subsequent annual updates.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. Personal protective equipment was available for staff to use and staff were able to describe how they would use these in order to comply with the practice's infection control policy. The policy also included needle stick injuries and bodily fluid spillages.

### Equipment

Staff we spoke with told us they had sufficient 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment such as the medicine fridge thermometers and we saw that emergency and resuscitation equipment was regularly checked.

### Staffing & Recruitment

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to

## Are services safe?

meet patients' needs. We saw there was a rota system in place for all the different staffing groups as well as a weekly planning meeting to review staffing levels at all three sites used by the practice to ensure they were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

The practice manager told us about staffing challenges the practice had faced over the previous year and how the practice had worked to keep services available to patients. For example, the practice is part of a federation of local practices and had been able to draw on administration and dispensing staff from other practices in the federation to fill some of the gaps. In addition, some members of staff had been trained in several roles to enable them to cover for colleagues where necessary. In this way, healthcare assistants and administration staff were able to cover reception duties, nurses were able to cover healthcare assistants and the practice manager had been appropriately trained to work in the dispensary as well as covering reception.

### **Monitoring Safety & Responding to Risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks

of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety lead.

We saw that risks were assessed and discussed at GP partners' meetings and within weekly team meetings.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage medical emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Mitigating actions were recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, disruption to the practice's computer system and access to the building. The plan also contained relevant contact details for staff to refer to.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

The GPs and nursing staff we spoke with were familiar with current best practice guidance. One of the GPs acted as a lead for accessing and disseminating guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. For example, we saw that changes to the guidance for the prescription of anticoagulants (medicines used to treat blood clots or prevent blood clots from forming) had been followed. We saw minutes of practice meetings where new guidelines were disseminated and the implications for the practice's performance and patients were discussed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race did not bias this decision-making.

The GPs led in specialist clinical areas such as diabetes, and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff, in conjunction with the practice manager, managed the care and treatment of patients with long term conditions, such as diabetes, asthma and hypertension (high blood pressure). We found there were appropriate systems in place to ensure patients with long term conditions were seen on a regular basis. Every patient over 75 years had a named GP.

Patients who required palliative care (care for the terminally ill and their families) were regularly reviewed. Their details were passed to the out of hours service to ensure care would continue when the practice was closed.

### Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). The QOF rewards practices for providing quality care and helps to fund further improvements. We saw that there was a system in place to frequently review QOF data. The practice participated in a benchmarking process with other practices in the Herefordshire Clinical Commissioning Group (CCG) area. A CCG is an NHS body responsible for commissioning local healthcare services. This allowed practices to compare their performance against other practices within the CCG in areas such as attendances at A&E and prescribing of antibiotics. Data we looked at from the local CCG of the practice's performance in these areas was comparable to similar practices.

The practice had a system in place for completing clinical audit cycles. The practice showed us five clinical audits that had been completed recently. Following each clinical audit, changes to treatment or care were made where needed. We saw examples which included ear syringing appointments and an audit on two week wait referrals for patients with suspected cancer. Plans were in place to follow up both audits to determine whether the changes made had had a positive impact on outcome for patients.

Doctors in the surgery also undertook minor surgical procedures in line with their registration and NICE guidance. The staff had received appropriate training which was updated. A GP we spoke with confirmed that no recent audits had been carried out in respect of these minor surgical procedures and this is something the practice may wish to consider.

### Effective staffing

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

All staff undertook annual appraisals which identified learning needs. Staff interviews confirmed that the practice

# Are services effective?

## (for example, treatment is effective)

was proactive in providing training. For example a Healthcare Assistant we spoke with had originally started at the practice as a receptionist. They told us their ongoing training had been carried out through a combination of in house training and further training at a local hospital, and that as a result their skill set was expanding. A member of the administration staff told us they had recently been supported to undertake a management diploma. As the practice was a training practice, medical students in the third and fifth year of their studies had access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. This included the administration of vaccines. A practice nurse we spoke with, who had an extended role which enabled them to specialise in seeing patients with diabetes, was able to demonstrate they had appropriate training to fulfil this role.

### Working with colleagues and other services

We saw that the practice worked with other service providers to meet people's needs and manage complex cases. The practice held multidisciplinary team meetings to discuss the needs of patients with end of life care needs. Minutes from multi-disciplinary meetings between the practice, Macmillan nurses and district nurses demonstrated that patients who were receiving end of life care were provided with appropriately co-ordinated care. We saw that the practice used special notes to ensure that the out of hours service were also aware of the needs of these patients when the practice was closed.

Information from other health care providers was clearly recorded and monitored to ensure patient appointments, hospital discharge notifications, clinical specimens and test results had not been missed. Staff we spoke with were trained in these procedures.

### Information Sharing

There was a system in place for receiving, managing, reviewing and following up the results of tests requested for patients. Reception staff we spoke with clearly understood their role and responsibilities in handling these results and who the results were to be shared with.

The practice had systems in place to provide staff with the information they needed. An electronic patient record system called EMIS was used by all staff to coordinate, document and manage patients' care. All staff were trained

on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice's branch surgeries were linked to the same computer system so that patients' information was accessible to relevant staff at whichever surgery they chose to attend.

Electronic systems were also in place for making referrals through the Choose and Book system. The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital.

### Consent to care and treatment

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

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

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



# Are services effective?

(for example, treatment is effective)

## Health Promotion & Prevention

The practice offered all new patients registering with the practice a health check. If this was carried out by a practice nurse or health care assistant, the GP was informed of all health concerns detected and these were followed-up in a timely manner.

The practice identified patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with

learning disabilities and we saw that these patients were offered an annual physical health check. The practice also identified at risk groups such as those who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

We saw that women aged between 25 and 49 were invited to receive a cervical smear test every three years, and that those aged 50 to 64 were invited five yearly. A system was in place to recall patients when their next test was due.

# Are services caring?

## Our findings

### **Respect, Dignity, Compassion & Empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from patients who took part in the national NHS GP patient survey in 2013. The information we looked at indicated that patients were satisfied with how they were treated. For example, the data showed that the practice performed at a level above the national average in terms of the number of patients who would rate their experience at the practice as either 'good' 'very good'. 91.3% of patients who responded to said they would recommend the practice, which was above the national average.

Patients completed CQC comment cards to provide us with feedback on the practice. We received six completed cards and they were all positive about the service patients had experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Washable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. In one consultation room the practice used a moveable screen to protect patients' privacy and dignity. The practice manager told us they had tried to install privacy curtains in this room as well but that they had been repeatedly pulled down due to the layout of the room. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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

We saw that some clinical staff used the practice loudspeaker system to call patients in from the waiting area for their consultation, while others came into the reception area to call patients through. Clinical staff we spoke with told us they knew who their patients were who

had difficulty hearing and that they always came through to call these people. We saw that people who were hard of hearing were also identified on the practice's computer system so that appropriate adjustments could be made for them.

### **Care planning and involvement in decisions about care and treatment**

The national 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, the practice was above the national average for the number of patients who felt the GP was 'very good' at involving them in decisions about their care.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them 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.

Staff told us that translation services were available for patients who did not have English as a first language though they added they rarely, if ever, had to use these services.

### **Patient/carer support to cope emotionally with care and treatment**

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The practice was above the national average for the number of patients who felt that the GP or practice nurse treated them with care and concern.

Notices in the patient waiting room and information on the practice website also signposted people to a number of support groups and organisations, including a mental health reference group and a dementia support group. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.



## Are services caring?

Staff told us families who had suffered bereavement were called by their usual GP. They also told us the GPs gave their own telephone numbers to people who had suffered bereavement in case they needed further support.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. Practice staff told us that the patient list was steadily increasing in size and we noted that an additional nine patients had completed registration forms on the day of our inspection. We heard how sessions led by the practice nurses and Healthcare Assistants had been increased recently to match this growing demand.

The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Both NHS England and the CCG are organisations which are responsible for commissioning local healthcare services. We saw that the practice ran regular clinics across its three sites for people with long term conditions such as diabetes, coronary heart disease and asthma. A system was in place to ensure that people with stable long term conditions received a regular review.

There had been no changes to the existing partnership arrangements at the practice for the last 14 years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one, including those in five local care homes.

One of the partners was identified as a lead for children and adolescents in social care. We saw that looked after children had a named GP at the practice. We also saw evidence that the practice had weekly young person's clinic for 12 to 18 year olds. Young people were able to attend the clinic, either by appointment or by just dropping in for confidential advice in a safe environment on a range of topics that were relevant to them. We saw that appointments were timed to coincide with the local bus service. In addition, the practice ran 4US clinics in the local school. These have been financed using Prime Minister's Challenge Fund monies awarded to Taurus (the Herefordshire GP Federation).

The practice did not run a dedicated mother and baby clinic but was able to provide postnatal visits and was involved in antenatal care in conjunction with the Midwife. All of the GPs provided contraceptive services, while two GPs fitted contraceptive coils and one GP performed contraceptive implants.

We saw that patients with poor mental health had a named doctor who took a lead in their care. A system was in place to identify people in this population group who missed appointments and to follow them up to ensure their care needs were met. The practice reported that they had an effective working relationship with the local mental health trust. The practice also had access to support from a community psychiatric nurse. The practice took a holistic approach to the needs of people with poor mental health and had recently carried out an audit into how the physical health needs of people receiving antipsychotic medication were met.

### Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, although the practice reported low numbers of homeless people and travellers in the area, the practice had reached out to a group of traveller families and was in regular contact with them to monitor their health needs and ensure these needs were met. Staff we spoke with confirmed that they had come to know these families well.

The practice had access to online and telephone translation services for patients whose first language was not English. The practice provided equality and diversity training. Staff we spoke with confirmed that they had completed equality and diversity training.

The premises and services had been adapted to meet the needs of people with disabilities. The surgery building had a ramp and wide doors to allow easy access for people in wheelchairs, and there was a buzzer outside the door to alert reception staff if patients needed assistance. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice.

The practice kept a register of people living in vulnerable circumstances, and a computerised system which alerted staff to vulnerability in individual patient records.

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## Access to the service

The practice was open from 8:30am to 6pm on weekdays. We saw that additional appointments for emergencies could be added to the end of standard surgery sessions. In the national patient survey for 2013, 97.9% of patients who responded said they were able to obtain an appointment at the practice the last time they wanted to speak to a GP or a nurse.

Information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the surgery itself, in the practice information leaflet and on the practice's website.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to or they could wait to see the doctor of their choice. Patients were also able to book an appointment at any of the practice's branch surgeries which made it easier for them to be seen by a GP when they needed to.

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 & complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available in the waiting room, the patient information leaflet and on the practice website to help patients understand the complaints system. Patients we spoke with were aware of the process to follow should they wish to make a complaint, but had never needed to use it. During our inspection we saw a patient hand in a formal complaint at the reception desk which demonstrated that patients knew how to use the system.

We looked at eight formal complaints received in the last twelve months and found these had been handled and resolved promptly in line with the practice's complaints policy.

The practice reviewed complaints on an on-going basis to detect themes or trends. We checked the reviews and saw that no consistent themes had been identified; however lessons learnt from individual complaints had been acted upon. For example, following a complaint about the content of a letter received by a patient following a referral, the practice took action to make sure the same mistake would not be repeated.

# 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's vision was to provide high quality and accessible family medicine as an integral part of a rural community. We spoke with 10 members of staff and they all knew and understood this vision and knew what their responsibilities were in relation to this. We looked at minutes which showed that this value had been reiterated at quarterly staff meetings.

### Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at 12 of these policies and procedures and saw they had been reviewed recently and were up to date.

The practice had named leads in areas such as governance, infection control, health and safety and safeguarding. We saw that arrangements were in place to ensure these roles were covered when the named lead was away from the practice, for example when they were on sabbatical or annual leave. Staff we spoke with were clear who the various leads were. We saw that regular governance meetings took place. Minutes we looked at from recent meetings showed that performance, quality and risks had been discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF rewards practices for providing quality care and helps to fund further improvements. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice used clinical audit to monitor quality and systems to identify where action needed to be taken. The practice had carried out a number of clinical audits, for example in monitoring the physical health of patients receiving antipsychotic medicines which had been carried out in 2014. The audit identified areas where improvements could be made, such as in reminding GPs of the practice's mental health protocol and educating patients in the importance of physical health monitoring. We saw that a repeat of the audit was planned to review the effectiveness of the improvements.

### Leadership, openness and transparency

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

We saw from minutes that practice meetings were held regularly and that meetings for staff from all three surgeries were held every three months. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

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

The practice had an active patient participation group (PPG) which met bi-monthly. PPGs are an effective way for patients and GP practices to work together to improve the service and to promote and improve the quality of care. We looked at records which showed the PPG included patient representatives from various population groups, including older people, male and female students, carers, people with long term conditions, people with a disability, people with young children and people of working age, including some who had recently retired. We saw that the PPG was had identified where its membership could be more inclusive and was actively attempting to recruit members aged between 20 and 40 and from the Eastern European community.

A representative we spoke with from the PPG confirmed that the members of the group felt listened to and valued. The PPG had carried out annual surveys and the results and actions agreed from these surveys were available on the practice website. We saw that the practice had acted on suggestions arising from the PPG's 2013 report, including a suggestion for dispensing staff to review the wording they used when people came to pick up prescriptions. We saw that a survey had also been carried out in February 2014. One of the actions arising from this was for a review of the practice information leaflet. Meeting minutes showed that the group had been involved in producing a revised version

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of the leaflet and practice terms of reference. We saw that the PPG had also provided information for the parish magazine which aligned with the practice's vision of integration into the local community.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had recently suggested that a Healthcare Assistant should be enabled to work across the practice's three surgeries. They told us their suggestion had been adopted and was due to be implemented during the coming month. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Staff we spoke with were clear about their whistle blowing responsibilities. Whistle blowing is when a former or current member of staff raises concerns about potential risk, malpractice or wrongdoing in their organisation. Staff told us they would know where to find the practice's whistle blowing policy, but were unable to do so in practice when we asked them to. We raised this with the practice

manager who took immediate steps to make a current whistle blowing policy available to all staff and to ensure that whistle blowing was specifically covered in the staff induction programme.

## **Management lead through learning & improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place. Staff told us that the practice was very supportive of training. We saw that staff had protected learning time four times a year where guest speakers attended, covering topics such as information governance, data protection and confidentiality. They also told us they met outside of surgery hours every six months for this purpose.

The practice was a training practice for medical students in the third and fifth year of their studies. All of the GPs at the practice were involved in the training programme.

The practice had completed reviews of significant events, complaints and other incidents and shared the results with staff via meetings and protected learning time to ensure the practice improved outcomes for patients.