Harrold 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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Harrold Medical Practice on 8 March 2016. Overall the practice is rated as good.

Our key findings across all the areas we inspected were as follows:

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

However there were one area where the provider must make improvements:

- Ensure that the roles of non-clinical staff, including those that carry out chaperoning, are risk assessed to determine whether criminal records checks are required.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Non-clinical staff did not have the required background checks needed to be carrying out chaperoning duties. We were informed that non-clinical staff were never left alone with patients and very rarely acted as chaperones, although there was no formal risk assessment in place. Immediately following our inspection we were sent evidence that the practice had formalised their risk assessment of non-clinical staff performing chaperoning duties.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average for the locality and compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. For example, meeting with MacMillan nurses to support patients requiring end of life care.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the national GP patient survey published 7 January 2016 showed patients rated the practice similar to others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, through the provision of enhanced services for avoidance of unplanned hospital admissions.
- Patients said they found it easy to make an appointment with a named GP and there was 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.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

- The practice had a clear ethos to deliver high quality care and promote good outcomes for patients, whilst maintaining a patient centred approach. The practice was engaged with the local community and staff took pride in the caring approach the practice promoted to ensure that every patient felt they were well cared for.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.

Summary of findings

- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on.
- There was a strong focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The Flu vaccination rate for the over 65s was 75% which was comparable to national averages.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the CCG and national average. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 85% where the CCG average was 90% and the national average was 88%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.

Summary of findings

- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.
- Contraceptive and sexual health advice was provided.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- Patients were able to book appointments with GPs online.
- The practice website was updated regularly and provided a broad range of information and advice to patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- Electronic records alerted staff to patients requiring additional assistance.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 74% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which was below the national average of 84%.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 92% where the CCG average was 87% and the national average was 88%.
- 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 told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing above local and national averages. 243 survey forms were distributed and 118 were returned. This represented 2% of the practice's patient list.

- 96% found it easy to get through to this surgery by phone compared to a CCG average of 77% and a national average of 73%.
- 92% were able to get an appointment to see or speak to someone the last time they tried (CCG average 86%, national average 76%).
- 95% described the overall experience of their GP surgery as fairly good or very good (CCG average 86%, national average 85%).
- 88% said they would definitely or probably recommend their GP surgery to someone who has just moved to the local area (CCG average 78%, national average 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 42 comment cards, of which 40 which were positive about the standard of care received. Patients said that the clinical and administrative staff members were welcoming, professional and supportive.

We spoke with five patients during the inspection. All five patients said they were happy with the care they received and thought staff members were approachable, committed and caring.

Harrold Medical Practice

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 specialist advisor, a practice manager specialist advisor and a pharmacist specialist advisor.

Background to Harrold Medical Practice

The Harrold Medical Practice provides a range of primary medical services, including minor surgical procedures from purpose built premises on Peach's Close in Harrold in rural Bedfordshire. The catchment area spans parts of the three counties of Bedfordshire, Buckinghamshire and Northamptonshire. There is a dispensary at the practice that provides medicine for patients who live more than one mile from a pharmacy.

The practice serves a population of 6,117 patients, with higher than average populations of both males and females aged 10 to 14 years and 40 to 84 years. There are lower than average populations aged 0 to 9 years and 15 to 39 years. The practice population is largely white British. National data indicates the area served is one of low deprivation.

The clinical staff team consists of one male and one female GP partner, a female salaried GP, a minor illness nurse and a practice nurse. A regular locum nurse attends the practice once a week. The clinical team is supported by a practice manager and a team of administrative support staff. The practice holds a General Medical Services (GMS) contract for providing services.

The practice is open between 8.30am and 6.30pm Monday to Friday. In addition to these times the practice operates extended surgery hours on Tuesdays for nurse appointments from 6.30pm to 8.15pm. Patients requiring a GP outside of normal hours are advised to phone the NHS 111 service.

The registration of the Harrold Medical Practice was not accurate at the time of our inspection as we had not been notified of changes made to the partners at the practice, as required under the CQC (Registration) Regulations 2009. The practice has now taken steps to complete the necessary application to ensure their CQC registration is accurate.

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. The 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.

How we carried out this inspection

Before inspecting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced inspection on 8 March 2016. During our inspection we:

Detailed findings

- Spoke with a range of staff, including two GP partners, two nurses and the practice manager.
- Spoke with patients who used the service and the manager at a local community home for individuals with learning disabilities and complex needs who were supported by the practice.
- Observed how staff interacted with patients.
- Spoke with a member of the patient participation group (PPG). (This was a group of volunteer patients who worked with practice staff on how improvements could be made for the benefit of patients and the practice).
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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.

Requires improvement

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of significant events.

We reviewed safety records, incident reports, MHRA (Medicines and Healthcare products Regulatory Agency) alerts, patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice. For example, the practice received a medicines recall alert for an anti-sickness medicine. We saw that the dispensary staff checked for stock of the medicine, took the appropriate action and kept signed records to validate the action taken.

When there were unintended or unexpected safety incidents, patients received reasonable support, an explanation of events, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, we saw that when a patient was provided with the incorrect dosage of a medicine the practice were proactive in taking prompt action to investigate the incident and issue an apology to the patient. The practice then changed their associated protocols to ensure that the risk of recurrence was minimised and all appropriate staff were informed and trained on new procedures.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training to a level appropriate to their role. GPs were trained to an appropriate level to manage safeguarding concerns.
- Notices in the waiting room and clinical rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and all clinical staff had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We were informed that non-clinical staff were never left alone with patients and very rarely acted as chaperones, although there was no formal risk assessment in place. Immediately following our inspection we were sent evidence that the practice had formalised their risk assessment of non-clinical staff performing chaperoning duties and recorded it as part of their chaperoning policy.
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be visibly clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, we saw plans to replace taps and sinks during planned building renovations to improve their suitability for use within a clinical setting. The practice had implemented interim measures to maintain good standards of infection control.
- All single use clinical instruments were stored appropriately and were within their expiry dates. Where appropriate, equipment was cleaned daily and daily logs were completed. Spillage kits were available and clinical waste was stored appropriately and was collected from the practice by an external contractor on a weekly basis.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local medicines management team, to ensure

prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms for use in printers and those for hand written prescriptions were securely stored and handled in accordance with national guidance. Patient Group Directions (PGDs) had been adopted by the practice to allow nurses to administer medicines in line with legislation. Healthcare assistants (HCAs) were able to administer vaccinations. Records showed that the staff had been assessed as competent for this role.

- Medicines alerts were shared with the dispensary staff and they were invited to daily lunchtime meetings with the GPs, nurses and practice manager to discuss any areas of concern relating to prescribing. One of the GP partners was responsible for supervising the dispensary.
- We reviewed two personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the administration office which identified local health and safety representatives. In addition the practice provided staff with an employee safety handbook. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health (COSHH) and infection control and Legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff told us they worked flexibly to provide additional cover during holidays and periods of sickness if needed.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room. There was an emergency room in the practice which was used to monitor patients awaiting an ambulance or for those causing concern on arrival at the practice. Staff we spoke with said they felt appropriately trained to deal with a medical emergency. During our inspection we saw that a patient waiting for his appointment was noted by reception staff as appearing unwell. They spoke to the patient before alerting a nurse who immediately transferred the patient in a wheelchair to the emergency room where he was monitored until a doctor was able to see him.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. A copy of the plan was kept off site by the practice manager, deputy practice manager and GP partners. The plan included emergency contact numbers for staff and there was a cascade system in place to alert staff of sudden closure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to keep all clinical staff up to date, including monthly clinical meetings where best practice guidelines were routinely discussed. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met people's' needs. NICE guidelines were incorporated into chronic disease management templates used to guide the clinicians when treating patients. Computer software was used to ensure clinicians were using up to date guidelines for the prescribing of medicines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results showed the practice achieved 92% of the total number of points available, with 7% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). Data from 2014/2015 showed;

- Performance for diabetes related indicators was similar to the CCG and national average. For example, the percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months was 85% where the CCG average was 90% and the national average was 88%.
- The percentage of patients with hypertension having regular blood pressure tests was 85% which was similar to the CCG average of 81% and national average of 84 %.
- Performance for mental health related indicators was similar to the national average. For example, the percentage of patients with diagnosed psychoses who had a comprehensive agreed care plan was 92% where the CCG average was 87% and the national average was 88%.

The practice was an outlier for one area of QOF which was for the percentage of patients with diagnosed psychoses whose alcohol consumption had been recorded in the preceding 12 months. The practice value was 62% compared to a national average of 90%. Upon investigation we were shown evidence that the practice had made repeated efforts to review alcohol consumption for these patients but with little success as these patients were often not willing to share this information.

Clinical audits demonstrated quality improvement.

- There had been four clinical audits completed in the last two years, all of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. Regular audits of atrial fibrillation were carried out to ensure patients were offered optimum support for stroke prevention and to enable patients to make informed choices about the care and treatment provided.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. It covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff for example, for those reviewing patients with long-term conditions. Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support

Good

Are services effective?

(for example, treatment is effective)

during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months. We saw that staff were encouraged to develop their skills and career opportunities and were supported to access formal training where requested. For example, a receptionist had attended a management training course.

- Staff told us they attended training days and made use of e-learning training modules where needed to maintain their knowledge and skills. However some staff informed us they occasionally found it hard to complete e-learning modules as there was little protected time for staff training. They also advised us that the practice were aware of this and that managers and GPs were in the process of securing more protected learning time for staff. Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their computer system. This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available. The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. The practice held a register of patients at risk of unplanned hospital admission or readmission and we saw that patients on this register were discussed at monthly multi-disciplinary case management meetings when needed. At the time of our inspection there were 253 patients on this register. We saw evidence that multi-disciplinary meetings were attended by local district nurses and that care plans were routinely reviewed and updated.

The practice held multi-disciplinary team (MDT) meetings that made use of the gold standards framework (for palliative care) to discuss all patients on the palliative care register and to update their records accordingly to formalise care agreements. They liaised with district nurses, MacMillan nurses and local support services. A list of the practices palliative care patients was also shared with the out of hours service to ensure patients' needs were recognised.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant services.
- Nurses provided weight management and smoking cessation advice to patients with the option to refer patients to local support groups if preferred.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the national average of 82%. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 98% and five year olds from 97% to 100%.

Flu vaccination rates for the over 65s were 75%, and at risk groups 49%. These were also comparable to CCG and national averages.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. At the time of our inspection, for the period from June 2013 to February 2016 the practice had completed 841 of 1,698 eligible health checks for the 40-74 age group. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in all but one of the consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments. The remaining room had a lock on the door and staff advised us of measures they took to respect patient privacy, for example, offering them a disposable cover and ensuring they turned their backs while patients prepared for examination. We were told of plans to ensure curtains were available in all treatment rooms as part of the planned refurbishment.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- We observed staff supporting patients and speaking to them with compassion and consideration. For example, we saw staff react quickly to a patient who was particularly unwell on arrival at the practice, to ensure he received appropriate care quickly.

40 of the 42 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with a member of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required. For example, by offering to take patients home if they could not arrange transport, or by delivering medicines to vulnerable patients in their rural community who had restricted access to transport.

Results from the national GP patient survey published 7 January 2016 showed patients felt they were treated with compassion, dignity and respect. The practice was in line with other practices locally and nationally for its satisfaction scores on consultations with GPs and nurses. For example:

- 82% said the GP was good at listening to them compared to the CCG average of 87% and national average of 87%.
- 87% said the GP gave them enough time (CCG average 86%, national average 87%).
- 94% said they had confidence and trust in the last GP they saw (CCG average 94%, national average 95%).
- 81% said the last GP they spoke to was good at treating them with care and concern (CCG average 83%, national average 85%).
- 94% said the last nurse they spoke to was good at treating them with care and concern (CCG average 92%, national average 91%).
- 95% said they found the receptionists at the practice helpful (CCG average 88%, national average 87%).

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views. Comments highlighted that patients felt they were listened to and that their needs were met accordingly.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 86%.
- 77% said the last GP they saw was good at involving them in decisions about their care (CCG average 79%, national average 82%).
- 89% said the last nurse they saw was good at involving them in decisions about their care (CCG average 86%, national average 85%).

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. We saw that the practice worked closely with local charities to ensure patients were signposted to services and support. For example, staff told us they had close links with Village Agent from Bedfordshire Rural Charities Commission who provide help and support to vulnerable patients. The practice also worked closely with a local charity offering support to individuals who had previously been homeless and often had a history of drug and alcohol misuse and/or mental health concerns.

The practice's computer system alerted GPs if a patient was also a carer. The practice was proactive in encouraging carers to identify themselves to ensure they were supported. Despite their efforts they had only identified 0.8% of their population as carers. At the time of inspection, the practice was considering additional methods for identifying and supporting carers. Written information was available to direct carers to the various avenues of support available to them. We spoke to a carer on the day of our inspection who told us they were well supported by the practice and staff were understanding when arranging appointments and were compassionate to the requirements of patients with complex needs.

Staff told us that if families had suffered bereavement, their usual GP contacted them and the practice sent them a sympathy card. This call was usually followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, one of the GPs advised the CCG on the development of templates used for reviewing patients with long term conditions such as diabetes and asthma to ensure patients were receiving consistent care across the locality. In addition to providing various enhanced services, such as avoiding unplanned admissions, the practice held multi-disciplinary team (MDT) meetings to discuss the needs of palliative care patients, patients with complex needs and patients who were at risk of unplanned hospital admissions.

We saw that patients with diabetes received an annual health review at the practice, with an interim basic check at six months. A diabetic retinal screening van was hosted by the practice on site once a year. The practice offered flexible appointments for reviews rather than set times and clinics to facilitate patients' preferences and needs. There were also registers for patients with dementia and those with a learning disability. These patients were invited in for an annual review in their birthday month.

- The practice offered extended hours on Tuesday evenings from 6.30pm to 8.15pm for nurse appointments for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who would benefit from these.
- Same day appointments were available for children and those with serious medical conditions.
- Appointments were available outside of school hours for children.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available.
- There were baby changing facilities, provisions for mothers wishing to feed their infants and an area in the waiting room specifically for children.
- There was a facility for patients to make online appointments and repeat prescription requests.
- A monthly sexual health clinic was held at the practice, led by a GP and supported by a nurse.
- The practice provided support to a community home for individuals with learning disabilities and complex health needs through visits to the home and the availability of urgent appointments when needed.
- The practice provided a service to support the mental health outreach team enabling them to collect blood samples for patients from the practice rather than at the hospital, should it be the more suitable option for the patient.
- The practice had arrangements with a local volunteer group and local village shops for the delivery and collection of medication to ensure patients with limited transport were able to receive their medicines. We saw evidence that the practice had risk assessed these arrangements to ensure medicines were stored and managed safely.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday and received telephone calls from 8am each day. In addition to these times the practice operated extended surgery hours for nurse appointments on Tuesday from 6.30pm to 8.15pm. Patients requiring a GP outside of normal hours were advised to phone the NHS 111 service. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. The dispensary was open Monday, Wednesday, Thursday and Friday from 8.30am to 6.30pm, on Tuesdays from 8.30am to 8.15pm and on Saturdays from 8.30am to 1pm.

Results from the national GP patient survey published 7 January 2016 showed that patients' satisfaction with how they could access care and treatment was better than local and national averages.

- 82% of patients were satisfied with the practice's opening hours compared to the CCG average of 76% and national average of 78%.
- 96% of patients said they could get through easily to the surgery by phone (CCG average 77%, national average 73%).
- 46% of patients said they always or almost always see or speak to the GP they prefer (national average 36%).

Good

Are services responsive to people's needs?

(for example, to feedback?)

People told us on the day of the inspection that they were able to get appointments when they needed them. The practice also managed a voluntary transport service for vulnerable patients which would take them to the surgery or to hospital appointments if needed.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available in the waiting area and on the practice website to help patients understand the complaints system.

We looked at eight complaints received in the last 12 months and found they had been dealt with in a timely manner, with openness and transparency. The practice offered apologies when necessary. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. For example, we saw that the practice received a complaint from a patient regarding conflicting information they were provided by practice staff. The practice investigated the incident, issued an apology and explanation to the patient whilst ensuring that staff received adequate training and advice to reduce the risk of recurrence.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear ethos to deliver high quality care and promote good outcomes for patients, whilst maintaining a patient centred approach. The practice was engaged with the local community and staff were proud of the caring approach the practice promoted to ensure that every patient felt they were well cared for. Their statement of purpose outlined their aims and objectives to deliver excellent patient care in a suitable environment with appropriately trained staff. It also highlighted the commitment to working alongside multi-disciplinary teams to ensure patients received the best possible outcomes wherever possible.

The practice were aware of future challenges they faced with regard to their sustainability to continue offering the high level of care they were committed to as well as the impending retirement of some long standing members of staff. We were told that they regularly discussed and planned for the future of the practice at monthly partnership meetings. We were also told of plans to complete the refurbishment of the building when adequate funds were available.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Staff understood the GP partners were the overall decision makers strongly supported by the practice manager, but were encouraged to provide feedback.
- Practice specific policies were implemented and were available to all staff.
- There was a comprehensive understanding of the performance of the practice. The practice used the Quality and Outcomes Framework (QOF) and other performance indicators to measure their performance. Data for this practice showed it was performing in line with other practices locally and nationally.
- There was a programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The practice manager and deputy practice manager operated an open door policy and we witnessed regular, informal communications between staff members, managers and the GPs.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

- The practice gave affected patients reasonable support, an explanation of events and a verbal and written apology.
- They kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- There were regular meetings and staff were encouraged to contribute to these.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues with colleagues and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners and practice manager. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The practice had seen a decline in membership of its PPG and the role of the remaining four members was focused on administering funds donated to the practice. For example, they had used donated funds to purchase a blood pressure monitor for the waiting area and additional blood pressure monitors that could be loaned to patients for home monitoring. The practice had tried, with limited success, to encourage membership of a virtual PPG (vPPG) which enabled members to engage using the internet and email. Although there were 40 members of the vPPG, the group's involvement with the practice was minimal. Despite this the practice continued to make efforts to engage with the vPPG and encourage their feedback and contribution to the practice.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, staff had recommended introducing a nurse led minor illness clinic and travel vaccine service. Both of these recommendations were implemented with positive results. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. They engaged with their local population to ensure they were familiar and understood the needs of their patients. They were proactive in developing a volunteer driver scheme for patients who were unable to arrange transport, which was particularly valuable for the elderly (who equated to 22% of the practice's patient population). Recognising the remote nature of the surrounding villages they served, the practice had arranged remote collection sites for medicines in three local villages to ensure patients were able to receive their medicines.

We spoke with a representative of a local community home for individuals with learning disabilities who told us the practice was pre-emptive in developing systems to improve outcomes for these patients. For example, the practice had initiated a system of using dosette boxes (used to organise medicines by times and days), filled by the dispensary team, to ensure these patients were taking their medications correctly.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment How the regulation was not being met: The provider had not risk assessed the roles of non-clinical staff, including those who act as chaperones, to assess whether a criminal records check was required. This was in breach of Regulation 12(1) (2) (a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014