Dr J D Sleath & Dr R G Warner

Quality Report

Kingstone Surgery
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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?	**Outstanding**
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 Dr J Sleath and Dr R Warner (Kingstone Surgery) on 28 April 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, responsive and well led services. It was outstanding for providing caring services. The practice was good for providing services to older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), those experiencing poor mental health or living with dementia and people whose circumstances may make them vulnerable. The practice required improvement for providing safe services.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses.
- Patients' needs were assessed and the practice planned and delivered care following best practice guidance.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had an established and well trained team with expertise and experience in a range of health conditions.
- Patients described the practice as caring, professional and competent. They commented on the availability of appointments, being cared for promptly, the GPs' human touch and the warm relaxed atmosphere.
- People valued having a local GP practice and the service it provided. We were told that the practice was a cornerstone of the community.
- Information about services and how to complain was available and easy to understand. The practice responded to complaints in a positive way.
- The practice communicated with patients and acted on feedback to improve the service they provided.

Summary of findings

We saw several areas of outstanding practice including:

- The practice had a strongly embedded focus on providing a caring service based on individual need and prided itself on the quality of relationships it built with patients. The impact of this was reflected in very positive patient feedback about the care and compassion they were shown.
- The practice provided very good flexibility of access to appointments. Patients could book appointments up to six months in advance and on the day. There was an open surgery every day which patients could attend without an appointment. The practice provided two morning surgeries a week between 7 and 8am and would see patients outside core surgery hours in certain circumstances. The GPs were committed to seeing patients on the same day if they wanted or needed this. The impact of this provision was reflected in very positive patient feedback about their ability to get appointments.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. This must include regular audits of infection prevention and control, arrangements for calibrating equipment used for patient care and a review of policies and procedures to ensure they reflect current legislation and national guidance.

In addition the provider should:

- Establish records to confirm that the contents of GPs' bags are regularly checked.
- Establish records of blank prescriptions in line with guidance from NHS Protect.
- Ensure that the competence of staff completing portable appliance checks meets the expectations in guidance from the Health and Safety Executive.

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 as there are areas where it must make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, some systems and processes were not implemented well enough to ensure patients were kept safe. These related to systems to support effective infection prevention and control, some aspects of checks made to ensure staff suitability, records of blank prescriptions, and arrangements for calibration of equipment to ensure that it was working correctly. Some policies and procedures had not been recently reviewed to ensure they reflected current legislation and guidance.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff were aware of and took account of guidance from the National Institute for Health and Care Excellence in the care and treatment they provided. The GPs and practice nurses knew patients well and aimed to provide an individualised service based on each patient's specific needs. This included being aware of patient's capacity to make decisions and encouraging them to take responsibility for their health. Staff had received training appropriate to their roles and the practice supported them to develop their knowledge and skills. Staff received annual appraisals and had training needs assessments. Staff worked in partnership with other professionals involved in providing care and treatment to patients.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than the national average in almost all of the areas measured. Feedback from patients about their care and treatment was extremely positive and emphasised the helpfulness, compassion and support they received from their GPs and the rest of the practice team. The practice saw their role as providing lifelong, personalised care and treatment to patients and believed this was most effective when provided by GPs that patients knew and trusted. Information from patients provided positive examples of care and support the practice had provided.

National data and information we received direct from patients showed that the practice gave patients the time they needed to

Summary of findings

discuss their health concerns. Patients felt they were treated with care and concern and were not rushed. The practice team took confidentiality and privacy seriously. Views of external stakeholders were very positive and echoed our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice understood the needs of its local population and the particular challenges of being in a rural location. Patients valued the availability of a local GP practice and many emphasised its essential role in the heart of the rural community

The practice prided itself on providing continuity of care. National data and information we received direct from patients confirmed they could frequently get an appointment with their preferred GP. The practice was very flexible in providing appointments - patients could book appointments six months in advance, on the same day or attend an open clinic each morning without an appointment. There was a very high level of patient satisfaction with the practice's opening hours, ease of getting through by telephone and the availability of appointments. 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 the practice responded quickly when issues were 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 GP partners had a clear vision to continue to provide individualised care to the local community as the practice had done for many years. They recognised that they also needed to adapt and develop taking into account factors outside their control such as the possibility of additional local housing. The staff we spoke with were as committed to the future of the practice as the GP partners. The practice had appointed a new practice manager who was committed to the future of the practice and was initially being supported by the retiring practice manager to ensure a smooth handover.

There were a range of meetings for the practice team to learn and share knowledge and information. The practice had a number of policies and procedures to govern activity and these were available for all staff to access on the practice computer system.

The practice had a positive relationship with the patient participation group (PPG) and sought suggestions for improvements from them.

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. Patients over the age of 75 had a named GP and GPs and practice nurses visited patients at home if they were unable to travel to the practice for appointments. The practice encouraged patients to have annual flu vaccinations and national data showed that the practice's vaccination rates for patients over 65 were in line with the national average.

The practice offered personalised care to meet the needs of the older people in its population. They knew their patients well and had built up relationships with them over many years. Some older patients who gave us information said they had stayed in the area in order to remain with the practice. The GPs monitored the health of older patients to identify any deterioration in their health. The practice had systems to alert staff to patients with significant health and care needs and those at the end of their life. The GPs provided out of hours care themselves for patients nearing the end of life.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. The practice offered personalised care to meet the needs of patients with long term conditions. They knew their patients well and aimed to provide continuity of care; for example people were usually able to see their preferred GP. The practice encouraged patients to have annual flu vaccinations and national data showed that the practice's vaccination rates for patients with conditions which increased their risk were in line with the national average.

The practice arranged one appointment for patients with more than one condition to avoid repeat visits to the practice. The practice nurses contributed to the care of patents with long term conditions and completed checks and tests so the results were available for the GPs when they saw patients. Longer appointments and home visits were available when needed.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. The practice provided family planning advice and midwives and health visitors were provided with a room to use at the practice so pregnant women and families with babies and young children could access all their healthcare in one place. They held an integrated clinic once a week with a midwife and health visitor to

Summary of findings

promote effective communication. Childhood immunisation rates were similar to or higher than the local CCG percentage The GPs and practice nurses worked with other professionals where this was necessary, particularly in respect of children living in vulnerable circumstances. Appointments were available outside of school hours.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people, recently retired people and students. The practice building was open from 8am to 6.30pm. The practice provided patients with detailed information about the times when each GP and nurse were available and scored highly in national surveys for patients being able to book appointments with their preferred GP. Appointments were available between 8am and 6pm each day and between 7am and 8am on Mondays and Tuesdays. GPs continued to see patients after 6pm if needed. Patients could pre-book appointments up to six months in advance, book an on the day appointment or attend an 'open appointment' session after the main morning surgery. The practice also offered telephone consultations and email consultations if requested by individual patients.The practice provided patients with information about local extended access and open access primary medical services. Patients could book appointments and order prescriptions online.

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. There were no patients from travelling communities in the practice catchment. The practice provided annual health checks for people with a learning disability. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

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

The practice based their care and treatment on their knowledge of patients and their families in a holistic way and did not proactively screen patients for dementia. They were confident that their relationships with their patients resulted in them responding promptly and effectively when necessary. When patients came to

see them about issues which might be dementia related the practice arranged to review them regularly to monitor any deterioration. The practice worked in partnership with a specialist dementia nurse from the local NHS mental health trust.

The practice made a room available one day a week for a community mental health worker to see patients locally. They also provided a room one day a month for a local psychiatrist to arrange local appointments for their patients. The practice did not charge the mental health trust for this facility because they recognised the benefits to patients of being seen closer to home. People experiencing poor mental health received annual physical health checks.

Summary of findings

What people who use the service say

We gathered the views of patients from the practice by looking at 35 Care Quality Commission (CQC) comment cards completed by patients. We spoke with four patients on the day of the inspection, one of whom was a representative from the patient participation group (PPG), a group of patients registered with a practice who worked with the practice team to improve services and the quality of care. We also looked at the January 2015 GP patient survey results and Friends and Family test results from December 2014 to February 2015.

Examples of the practice's results from the January 2015 NHS England GP patient survey showed that of those patients who responded -

- 95% described their overall experience of the practice as good (CCG average 89%; national average 85%).
- 95% would recommend the practice (CCG average 81%; national average 78%).
- 98% of patients found the reception staff helpful (CCG average of 90%; national average 87%).
- 96% said the last GP they saw was good at giving them enough time (CCG average 89%; national average 87%).
- 95% found it easy to get through on the telephone (CCG average 79%; national average 73%).
- 92% were satisfied with the practice's opening hours (CCG average 76%; national average 75%).
- 87% of patients who preferred to see a particular GP were able to do so (CCG average 65%; national average 60%)

The practice's lowest scores in the survey were in line with the CCG and/or national averages and in some cases were higher.

Information from the NHS Friends and Family Test in January, February and March 2015 (45 returns) showed that 42 were extremely likely to recommend the practice and three were likely to.

The information from all these sources presented a positive picture of patients' experiences at Kingstone Surgery. Patients described the practice as caring, professional and competent. They commented on the availability of appointments, being cared for promptly, the GPs' human touch and the warm relaxed atmosphere. People valued having a local GP practice and the service it provided. We were told that the practice was a cornerstone of the community.

Some patients wrote comments about the practice environment describing it as clean, safe, hygienic and welcoming.

Areas for improvement

Action the service MUST take to improve

- Establish an effective system to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. This must include regular audits of infection prevention and control, arrangements for calibrating equipment used for patient care and a review of policies and procedures to ensure they reflect current legislation and national guidance.

Action the service SHOULD take to improve

- Establish records to confirm that the contents of GPs' bags are regularly checked.
- Establish records of blank prescriptions in line with guidance from NHS Protect.
- Ensure that the competence of staff completing portable appliance checks meets the expectations in guidance from the Health and Safety Executive.

Outstanding practice

- The practice had a strongly embedded focus on providing a caring service based on individual need

and prided itself on the quality of relationships it built with patients. The impact of this was reflected in very positive patient feedback about the care and compassion they were shown.

- The practice provided very good flexibility of access to appointments. Patients could book appointments up to six months in advance and on the day. There was an open surgery every day which patients could attend without an appointment. The practice provided two morning surgeries a week between 7 and 8am and would see patients outside core surgery hours in certain circumstances. The GPs were committed to seeing patients on the same day if they wanted or needed this. The impact of this provision was reflected in very positive patient feedback about their ability to get appointments.

Dr J D Sleath & Dr R G Warner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector. The team included a GP specialist advisor and a practice manager specialist advisor. A member of a Local Medical Committee from another area was present at the inspection as an observer.

Background to Dr J D Sleath & Dr R G Warner

Kingstone Surgery is in a village location in western Herefordshire. The practice has a catchment area of 170 square kilometres with relatively low levels of deprivation. It has around 4,300 patients who live mainly in the villages of Kingstone, Clehonger, Madley and the surrounding rural areas. Many patients are from established rural and farming families. There are no care homes in the practice's catchment area.

The practice has a car park with disabled spaces near the entrance. The current practice building replaced older premises in 2000 and was extended to meet the needs of increased patient numbers in 2010. The new building was purpose designed with input by the GP partners to create a safe and welcoming environment and won a Civic Trust Award. The design provides ease of access and the building is all on ground level with wide corridors and doorways.

The practice has two male GP partners and two salaried part time female GPs, two practice nurses and a phlebotomist (a member of staff trained to take blood). The clinical team are supported by a practice manager, assistant practice manager and office manager. The previous practice manager remains a key member of the team during a period of semi-retirement to enable a smooth handover to the new practice manager who had recently joined the practice when we inspected it. The practice has an established team of administrative staff and receptionists. The practice is a dispensing practice and employs a dispensary manager and five dispensary assistants.

The practice provides a range of minor surgical procedures.

The practice has a patient participation group (PPG), a group of patients registered with a practice who work with the practice team to improve services and the quality of care.

The practice has a General Medical Services (GMS) contract with NHS England.

The practice does not routinely provide out of hours services but does provide some out of hours cover for patients approaching the end of life. Information for general out of hours cover was provided for patients. This service is provided in Herefordshire by Primecare, a national company providing primary medical services.

Why we carried out this inspection

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

Detailed findings

Please note that references to the Quality and Outcomes Framework data in this report relate to the most recent information available to CQC at the time of the inspection.

How we carried out this inspection

Before this inspection, we reviewed a range of information about the practice and asked other organisations to share what they knew. These organisations included Herefordshire Clinical Commissioning Group (CCG), NHS England and Herefordshire Healthwatch. We carried out an announced visit at the practice, known as Kingstone Surgery, on 28 April 2015. Before the inspection we sent CQC comment cards to the practice. We received 35 completed cards which gave us information about those patients' views of the practice.

During the inspection we spoke with 10 staff including the practice management team, GPs, practice nurses and members of the dispensary, reception and administrative teams. We spoke with four patients one of whom was a representative of the Patient Participation Group (PPG).

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances

People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used significant events, national patient safety alerts and comments and complaints received from patients to monitor safety. They had used significant events to focus on safety and learning for 10 years and had a well-established significant events audit cycle. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. This was covered in annual health and safety training. We found some areas where the practice needed to make improvements. These related to checks on GPs' bags and the security of blank prescriptions, arrangements for auditing infection prevention and control and for cleaning privacy curtains, calibration of equipment used in the practice and information about checks to monitor the suitability of staff.

Learning and improvement from safety incidents

The practice management team received national patient safety alerts and circulated these to the members of staff who needed to act on them. These were also saved on the practice computer system where all members of the team could access them.

Staff checked and circulated any incoming alerts promptly. They discussed significant events and acted on them in a timely way based on assessment of the seriousness of the issue. The practice gave us an example of a significant event relating to a patient who received an incorrect dose of a blood thinning medicine. As a result the practice had changed their procedures for making sure patients had correct information in their individual record books. Another significant event resulted in the practice changing how they managed fax communications after one was not dealt with promptly.

Reliable safety systems and processes including safeguarding

The practice had a lead GP for safeguarding vulnerable adults and children. Staff were appropriately trained and understood their roles and responsibilities regarding safeguarding including their duty to report abuse and neglect. The GPs took part in meetings with other relevant professionals involved in safeguarding children and adults. These included six weekly meetings with the health visitor and district nursing teams.

The practice had safeguarding policies and procedures based on national and local guidance. Important contact numbers for the multi-disciplinary child and vulnerable adult safeguarding teams were readily available for staff to refer to. The practice had clear systems to alert staff to children or adults known to be living in circumstances that might place them at risk.

We saw that the practice had leaflets available in the waiting room about local safeguarding arrangements and about a local service for people needing support in respect of rape and sexual abuse.

Staff told us patients rarely asked for a chaperone and the GPs did not often need one due to the availability of male and female GPs. A chaperone is a person who acts as a safeguard and witness for a patient and health care professionals during a medical examination or procedure. The practice had a chaperone policy which staff were aware of. Staff at the practice had received in house chaperone training during staff training days. If a patient asked for a chaperone this was done by staff who had a Disclosure and Barring Service (DBS) check. DBS checks identify whether a person has a criminal record or is on an official list of persons barred from working in roles where they will have contact with children or adults who may be vulnerable. The practice did not provide information for patients about the possibility of asking for a chaperone in line with guidance from the General Medical Council (GMC). We saw that after the inspection they added this to the practice leaflet and they informed us they had put a sign up in reception.

Medicines management

The GPs had their own bags for home visits. The GPs took individual responsibility for checking the contents of these to make sure any medicines were in date and a practice nurse did monthly checks. The practice did not maintain records of these checks. The GPs did not carry controlled drugs (CDs) when they visited patients at home. CDs are medicines that require extra checks and special storage arrangements because of their potential for misuse.

We asked about the arrangements for the security of blank prescriptions. The practice stored blank prescription pads and printer sheets securely but did not keep records of prescription serial numbers or the allocation of prescriptions to the GPs in accordance with national guidance.

Requires improvement

Are services safe?

Patients could order repeat prescriptions by telephone, online or in person at the practice. The practice had a system to ensure repeat prescriptions were authorised by a GP before they were issued to patients. A GP was responsible for reviewing changes to patients' medicines while they were in hospital and updating this information in their records. The practice monitored patients on certain medicines where specific precautions are necessary. Dispensary staff communicated closely with the GPs in respect of problems such as patients requesting repeat prescriptions too often or not collecting their medicines. In certain circumstances the practice arranged for patients to have weekly prescriptions to so they could monitor patients more closely. The practice aimed to issue all repeat prescriptions within 48 hours.

The practice nurses were responsible for maintaining vaccine stocks. We saw that the practice had arrangements for the receipt, storage and recording of all vaccines coming into the practice. The practice nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance and had up to date copies of these to refer to. We saw evidence that staff monitored and recorded the temperatures of the fridges where vaccines and other temperature sensitive medicines were stored.

The practice had appropriate written procedures for the production of prescriptions and dispensing of medicines. The practice took part in the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. The dispensary was clean and organised with all medicines stored in a well-managed way. The practice had appropriate secure storage for CDs with clear records to provide and audit trail of the receipt and dispensing of these. Dispensing staff completed appropriate training and had annual appraisals. One of the GPs was the dispensing lead providing oversight and support to the dispensary team. They completed an audit in 2014 which looked at stock control and the availability of certain medicines. This highlighted a need to monitor certain medicines, including those for diabetes more closely and resulted in changes to processes to ensure that stock was always available.

Cleanliness and infection control

The practice was visibly clean and the practice had policies and procedures to help the practice manage infection prevention and control (IPC) and planned to review this during 2015. The IPC lead nurse from the clinical commissioning group (CCG) had completed two IPC audits during 2012. They had also delivered training to practice staff during 2013. No further IPC audits or formal training had taken place although this was a standing item during quarterly practice meetings.

Hand washing facilities and hand gel were available for staff and patients and staff had an adequate supply of personal protective equipment. The practice did not have a structured schedule to ensure that privacy curtains in treatment rooms were cleaned every six months in line with national guidance. Staff confirmed that they were regularly vacuumed but that they had not been taken down and laundered since 2010. We observed that the curtains looked visibly clean and were not stained.

The practice employed two housekeepers and we saw that a sluice sink, cleaning products and equipment were available for them to use. We saw that there was a cleaning schedule for the housekeepers to follow and that the practice nurses had an equipment cleaning schedule.

A policy and procedure was available about the action staff should take if they accidentally injured themselves with a needle or other sharp medical device. The practice had a process for confirming that staff were protected against Hepatitis B.

The practice had a legionella risk assessment which was reviewed in August 2014. Legionella is a bacterium that can contaminate water systems in buildings. The practice had contracts for the collection of non-clinical and clinical waste and suitable locked storage for all waste that was waiting for collection.

Equipment

The practice had the equipment they needed for the care and treatment they provided but did not routinely have equipment calibrated to ensure that readings were accurate. The practice had a lot of relatively new equipment and had not judged it necessary to arrange for this to be carried out. Staff at the practice checked the portable electric equipment annually. The practice judged that they were suitably competent to do so although they had not completed a structured course for this.

Staffing and recruitment

The practice had an experienced and skilled staff team with clear responsibilities and lines of accountability. The overall

Requires improvement

Are services safe?

staffing levels and skill mix at the practice ensured that they had sufficient staff to maintain a safe level of service to patients. They preferred to arrange cover for absences amongst the team and did not use agency staff or locums. They had a system to monitor staff availability.

We saw that the practice obtained the expected information for new members of staff they employed. The practice had made a decision that in addition to clinical staff they would obtain DBS checks for the practice manager and assistant practice manager. Non-clinical staff who were never left alone with patients did not have DBS checks. The practice did not have a formal written risk assessment regarding this as part of their recruitment procedures.

We saw that the practice checked the NHS England Performers list when they employed a new GP to work at the practice. The practice routinely checked the professional registration status of the practice nurses each year but did not do this for the GPs.

Monitoring safety and responding to risk

Two members of the management team had completed suitable health and safety training to enable them to train other staff regarding their responsibilities. They delivered this training annually. The practice had a health and safety policy file which included guidance and other information specific to the practice. This included risk assessments for topics such as fire safety and legionella. We noted that that practice had not reviewed some of the health and safety file contents since 2011 and 2013.

We noted that the sluice sink, mops and cleaning equipment for the housekeepers to use were in the same room as the practice's computer server equipment. Some of the computer equipment was positioned on the floor.

The practice had a brief risk assessment regarding the potential risks of the proximity of electrical equipment to staff using running water, buckets of water and wet mops, judging the likelihood of an accident to be low risk. The practice confirmed that the computer equipment was raised from floor level following the inspection and sent us a more comprehensive risk assessment. This included plans to re-organise the room and in the longer term to explore the possibility of separate rooms.

The practice information leaflet explained the practice's right to take action should patients be violent or abusive towards other patients or staff.

Arrangements to deal with emergencies and major incidents

The practice had oxygen, a defibrillator and emergency medicines available for use in a medical emergency. The practice nurses were responsible for checking the equipment and medicines to make sure they were available, in date and suitable for use. Staff completed annual cardiopulmonary resuscitation training.

The practice had a fire risk assessment and held fire drills. The practice had fire safety records confirming that they carried out fire alarm tests and regular checks of fire safety equipment. The GP and practice manager had completed external fire safety training in the past.

The practice had a business continuity plan covering a range of situations and emergencies that may affect the daily operation of the practice. The plan was available to all staff. Key members of the practice team and another local GP practice held copies off site. The practice had an adverse weather risk assessment and explained that enough staff lived locally to provide a skeleton service during extreme icy conditions.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had systems for distributing, discussing and saving current best practice guidance such as from the National Institute for Health and Care Excellence (NICE) and local sources such as NHS England. The practice team had access to these through the practice's computer system and used the information in their care and treatment of patients. The GPs and nurses gave us examples of discussing new guidance and situations where they used this to guide the action they took. A GP also showed us feedback they had submitted to NICE in response to guidance about diabetes care showing that they were aware of the guidance and had the knowledge base to challenge this.

The practice considered that accurate clinical coding was essential in ensuring patients received the correct treatment and follow up care. One of the GP partners summarised all medical notes arriving at the practice for new patients. They told us that as a result of the summarising being done in this way the practice had identified incorrect and missed coding of significant health issues. They had also identified information recorded about the wrong patient.

The practice had fewer patient accident and emergency attendances, emergency inpatients and secondary care referrals than the national average. Data showed an emergency admissions figure of 6.8% of the number of patients registered compared with the national figure of 9.1% and accident and emergency attendance figures of 22.8% compared with 33.1%. Admissions for a group of 19 specified conditions were also lower (9.89% compared with 14.4%). Some condition specific admission rates were also lower than the national average including for chronic heart disease, asthma and diabetes.

Management, monitoring and improving outcomes for people

The Quality and Outcomes Framework (QOF) is a voluntary incentive scheme for GP practices in the UK. Data available to us for 2013/14 showed that the practice had achieved 99.2% of the available points. This was 2.1% above the CCG average and 5.7% above the national average. We noted that for example -

- Performance for four out of five diabetes related indicators was between three and seven percentage points above the national average and the fifth indicator was the same as the national average.
- Performance for appropriate treatment of patients who had had fragility fractures with a bone sparing agent was above the national average (practice 100%; national 81.29%).
- Performance for treating patients who had atrial fibrillation with appropriate medicines was above the national average (practice 100%; national 98.33%)
- Performance for treating patients with high blood pressure was above the national average (practice 86.76%; national 83.13%).

The practice monitored the care and treatment needs of patients with long-term conditions. Patients had an appointment with the practice nurse for any tests and routine checks and then saw their GP to review the results. Patients with more than one condition had all these reviewed at the same appointment to avoid multiple visits to the practice. Patients could book these appointments when it was convenient for them rather than being restricted to specific clinic days. The practice checked which patients needed appointments by running a monthly search on the computer system. If patients did not book an appointment for their review the practice wrote to them to remind them.

We noted that the practice's prescribing of a specific group of antibiotics which should not be over prescribed was lower than the national average during the period 1 January 2014 to 31 December 2014 (1.03% compared with 5.33%). Prescribing of certain non-steroidal anti-inflammatory medicines which should be prescribed with caution was also lower than the national average during the same period (67.85% compared with 75.13%).

For the year 2013/14 QOF data showed the practice documented care plans for 80% of patients experiencing poor mental health compared with the national average of 86.04%. However, the practice had reviewed all these patients and had noted the alcohol consumption for all of them compared with the national average of 88.65%. The practice provided their as yet unpublished 2014/15 QOF data which showed that 87.5% of those patients had a documented care plan that year.

The practice provided patients with learning difficulties with health information in suitable formats for them to

Good

Are services effective?

(for example, treatment is effective)

understand. Longer appointments were arranged for those patients who needed more time to have information explained to them. All of the practice's older patients had a named GP.

The practice based their care and treatment on their knowledge of patients and their families in a holistic way and did not proactively screen patients for dementia. They were confident that their relationships with their patients resulted in them responding promptly and effectively when necessary. When patients came to see them about issues which might be dementia related the practice discussed their diagnosis and treatment with them. When it was appropriate they liaised with patients' families and the dementia nurse linked with the practice. They arranged to review patients living with dementia regularly to monitor any deterioration. Dementia diagnosis rates were in line with the CCG average. The practice's 2013/14 QOF data showed that 72% of patients with dementia had a face to face review compared with the national average of 83%. The practice provided their as yet unpublished 2014/15 QOF data which showed this had improved to 83%.

Clinical audits are a process by which practices can demonstrate ongoing quality improvement and effective care. The practice showed us examples of a number of clinical audit cycles which showed that they took a planned approach to reviewing the care and treatment they provided to patients. For example, one completed clinical audit cycle related to emergency admission referrals. This was thorough and looked in detail at patients' medical needs and confirmed that the decisions to refer them to receive hospital care were correct. The practice had also audited their two week wait cancer referrals and found these were appropriate. They were considering an audit of women's health referrals which they were aware were slightly high to check whether these were appropriate and had carried out similar audits in the past in respect of other referral types. Another audit had reviewed the outcomes for patients from joint injections to establish the benefits of these. The practice had established that certain joint injections had resulted in limited benefits. They included this information when discussing joint injections with patients to help them reach informed decisions about having the treatment. A nurse told us they were in the process of carrying out an audit of healing rates for leg ulcers.

Effective staffing

The practice had two full time male GP partners and two part time female salaried GPs. The GPs managed their leave to ensure that adequate cover was achieved. High importance was placed on continuity of care and the practice GPs covered each other's absences. The rest of the staff team also provided continuity of care due to low staff turnover.

The GPs took part in required annual external appraisals and had been revalidated. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by General Medical Council can the GP continue to practice and remain on the performers list with the NHS England. Other staff also received annual appraisals and had training needs assessments to identify learning needs.

GPs and nurses at the practice had five days protected learning time each year to take part in training activities to update their knowledge and skills and contribute to their required continued professional development (CPD). A salaried GP told us that they had been given a week's study leave to prepare for their appraisal and that the practice had met the cost of the appraisal process.

Working with colleagues and other services

The practice had the second lowest referral rates to secondary care within the CCG area. They attributed this largely to the continuity of care they provided and their knowledge of their patients.

The GPs worked closely with other professionals involved in the care of their patients including those living in vulnerable circumstances and those approaching the end of life. This included meetings with Macmillan nurses at least monthly but more often when necessary. They worked closely with mental health services, midwives, health visitors and community nursing teams. The local Parkinson's disease specialist nurse, a physiotherapist and an occupational therapist all held regular clinics at the practice adding to the range of services available to patients and improving communication.

The practice made a room available one day a week for a community mental health worker to see patients locally. They also provided a room one day a month for a local psychiatrist to arrange local appointments for their patients. The practice did not charge the mental health trust for this facility because they recognised the benefits to patients of being seen closer to home. The practice

Good

Are services effective?

(for example, treatment is effective)

promoted the Improving Access to Psychological Therapies' (IAPT) 'Let's Talk' scheme in consultations and by making literature available in the waiting room. The practice had a linked dementia nurse from the local mental health NHS trust attached to the surgery.

Information sharing

The practice had clear arrangements for providing information about patients with complex care needs including those receiving end of life care, to the out of hours and ambulance services. This included specific information about any patient who had made a decision that they did not wish to be resuscitated. The practice had a process for making sure test results and other important communications about patients were dealt with promptly. The GP partners monitored all incoming information about patients and the GPs contacted patients themselves about any test results where action was going to be needed. The GPs recorded any comments about results in patients' notes and the support staff scanned any paper correspondence received within 24 hours.

The practice held daily meetings after morning surgery where they shared and discussed clinical information. They did not keep a record of what was discussed at these meetings.

The practice was aware of its responsibilities in respect of information governance and patient privacy. The practice information leaflet provided patients with information about their rights and how the practice dealt with information they held about them. This included information about the Data Protection Act 1998 and the Freedom of Information Act 2000.

Consent to care and treatment

The GPs and nurses we spoke with understood the importance of gaining informed consent. The Mental Capacity Act 2005 (MCA) provides a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves. One of the GPs was the lead for MCA related issues and gave us examples of situations when they had needed to take this into account in making decisions about patients' care and treatment. The GPs had a very good level of understanding about the assessment of capacity being decision specific and that a person's capacity can fluctuate.

The GPs and nurses understood the need to consider Gillick competence when providing care and treatment to young people under 16. The Gillick test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

We saw evidence that verbal consent for minor surgery was recorded and coded in patients' notes. Some GPs at the practice did not use written consent forms for this while others did. We saw that the GPs recorded consent for intimate examinations.

Health promotion and prevention

The practice had an informative website which provided links to news and information about a wide range of health and care topics.

The practice nurses provided a range of appointments for a range of health checks and treatments. These included new patient health checks, reviews for patients with long term conditions, women's health, blood tests, wound assessments and treatment, baby immunisations and electrocardiograms. The practice provided one to one support to patients who found they were unable to stop smoking and had achieved 98.4% of the available QOF points for supporting patients to stop.

The practice provided family planning advice and midwives and health visitors were provided with a room to use at the practice so that pregnant women and families with babies and young children could access all their healthcare in one place.

Childhood immunisation rates were similar to or higher than the local CCG percentage. The practice encouraged patients to have annual flu vaccinations and national data showed that the practice's vaccination rates for patients over 65 years and those at risk were in line with the national average.

The practice nurses were responsible for the practice's cervical screening programme and the number of women screened was in line with the national average.

The practice website contained links to the NHS Choices website where they could obtain information about a wide range of topics including travel health information.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Information from the NHS Friends and Family Test in January, February and March 2015 (45 returns) showed that 42 were extremely likely to recommend the practice and three were likely to.

Additional comments from those patients and from those we received direct information from gave a positive view of the degree of care and compassion experienced by patients. Patients described staff as friendly, helpful and kind. They said the practice provided care with a human touch. All members of the practice team were mentioned; for example patients described reception staff as consistently polite and charming. During the inspection we saw reception staff speaking with patients in person and on the telephone. We noted the warmth of their approach and the interest they showed in patients'.

We spoke with reception staff about privacy for patients when telephoning the practice or speaking to staff at the reception desk. Staff explained that incoming calls were initially taken in the private part of the reception office and this meant that discussions took place where other patients could not overhear. If staff at the reception desk answered an incoming call they used the patient reference number rather than their name when transferring the call. The reception desk was away from the chairs in the waiting room and music was played to reduce the risk of conversations at reception being overheard. Patients could ask to speak with staff in a private room if they wished.

The practice had arranged staff training regarding confidentiality in response to a complaint and staff contracts contained a confidentiality clause.

Throughout the inspection we saw that the practice team aimed to provide a personalised service. This included the GPs collecting patients from the waiting room and walking back to the treatment rooms with them rather than using a screen or speaker system to call them.

In the January 2015 the NHS GP patient survey results showed that of the patients who responded -

- 98% of patients found the reception staff helpful (CCG average 90%; national average 87%).
- 93% of patients said the last GP they saw or spoke to was good at treating them with care and concern (CCG average 88%; national average 85%).
- 96% said the last GP they saw was good at giving them enough time (CCG average 89%; national average 87%).

Care planning and involvement in decisions about care and treatment

The practice saw their role as providing lifelong, personalised care and treatment to patients and believed this was most effective when provided by GPs that patients knew and trusted. The results of the January 2015 NHS GP patient survey showed that 84% of patients with a preferred GP were usually able to see or speak with that GP compared with the CCG average of 63%.

Information from patients confirmed that the GPs and nurses involved them in their care and treatment. Patients said they were listened to and that the GPs took time to make sure they had the full picture. They said the GPs took them seriously and never rushed them. The GPs we spoke with described the importance of giving patients sufficient time to discuss and understand their conditions and treatment options. The GPs also spoke about encouraging patients to take responsibility for their own health and involving family members and other health professionals when this was appropriate. Two of the GPs specifically talked about the need to accept patients' decisions even where these differed from their view and were likely to be life altering. A young person described how their GP spoke directly with them not above their head to their parent.

The GPs showed us examples of written 'decision aids' which they used to help them explain the risks and benefits of proposed treatments to patients. These were based on recognised evidenced based guidance such as information from the National Institute for Health and Care Excellence (NICE). One of the GPs explained they often gave this information to patients to take away and consider at their leisure.

Information from the January 2015 NHS GP patient survey showed that –

- 90% of patients said that the last GP they saw or spoke to was good at involving them in decisions about their care (CCG average 84%; national average 81%)
- 98% of patients had confidence and trust in the last GP they saw or spoke to (CCG average 97%; national average 95%)

Outstanding ☆

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The GPs provided their own out of hours cover for patients known to be nearing the end of their lives. They gave us an example of a patient a GP had stayed with for several hours so they were able to fulfil their wish to die at home. We spoke with a salaried GP who had been at the practice for three years. They told us they valued the ability to provide patients with continuity of care particularly at the end of life. They told us that in their experience the GP partners always put patients first and went the extra mile to support them. One patient gave an example of a GP visiting them at home to provide important test results because they had been unable to reach the patient by telephone. The GPs contacted patients about test results where treatment would be needed so they could answer their questions and reduce uncertainty.

Information to highlight that a patient also had carer responsibilities was recorded in their notes. The GPs described how they developed long standing relationships with patients and were aware of their needs, including whether they were a carer. The GPs felt that patients knew that the practice was very accessible and that the GPs were happy to have long conversations with them about their individual social as well as health needs. The practice had information about Herefordshire Carer Support and Herefordshire Young Carers displayed in the waiting room. Some patients who completed CQC surveys commented on the support the practice gave to them during their own or family member's illnesses.

The practice had various information in the waiting room for patients to refer to or pick up and take away. This included bereavement support information and details of organisations such as the Alzheimer's Society.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice team understood the makeup and needs of their patient population. They recognised that they did not have some of the challenges experienced by GP practices in many urban areas. The practice catchment area included three villages in a rural area of 170 square kilometres. Many patients were from long standing rural and farming families. The partners attended routine meetings of the Herefordshire Clinical Commissioning Group (CCG) to keep in touch with local developments.

The practice believed that one of their strengths was the continuity of care they provided to patients. They achieved this by being a small and stable team within which the GPs managed leave carefully so staffing levels were maintained. Staff and patients described the practice as being an essential and highly valued part of the local community. Local people had established a charitable trust in 2001 to raise funds for the practice. The practice had used the monies raised to buy equipment for the practice to benefit patients. We heard that one of the GPs regularly assisted at a local lunch club for older people and that the village had an exercise group which was originally set up by one of the practice nurses.

The GPs visited patients at home if they were unable to attend the practice due to their health or poor mobility. A practice nurse confirmed that this included visits for routine care such as flu vaccinations and ear syringing.

The practice made rooms at the practice available for other professionals to use so that patients could be seen closer to home. These included mental health practitioners, midwives, health visitors, a physiotherapist, occupational therapist and the local specialist Parkinson's Disease nurse.

Tackling inequity and promoting equality

The practice ethos was to provide care which took into account patients' whole situation, not just their physical health. Staff contracts included information about the practice's expectations regarding equality and diversity.

The practice was aware of the numbers of patients of other ethnic origins registered with the practice. These patients represented slightly over 1% of the patient list and so the practice rarely needed to arrange translation or interpreting services.

The practice team confirmed that there were no patients from travelling communities in their catchment area and that they had no homeless patients registered.

The building was purpose designed with input by the GP partners to create a safe and welcoming environment and won a Civic Trust Award in 2000. The design provided ease of access and the building was all at ground level with wide corridors and doorways. There was an accessible toilet and designated parking for patients with mobility difficulties. We noted that the accessible toilet did not have an alarm cord if a patient needed assistance as it was built before there was a requirement for this. The practice had judged that it was situated where reception staff would be aware if someone was a long time or called for help.

Access to the service

The practice placed great importance on providing their patients with a responsive and easy to access service. They told us this was because they recognised their role in improving the management of long term conditions and in reducing accident and emergency admissions. The practice provided information showing that they provided the third highest number of GP sessions (in relation to the number of patients) in Herefordshire. Information from patients showed they highly valued the availability of a local GP practice.

Information about appointment times was included in the practice booklet; this specified the times when each GP and practice nurse was available. They practice did not triage appointment requests and guaranteed same day access to see a GP every weekday between 8.30am and 6pm. GPs stayed at the practice after 6pm if there were patients who still needed to be seen. Appointments were available between 7am and 8am on Mondays and Tuesdays. Patients could pre-book appointments up to six months in advance, book an on the day appointment or attend an 'open appointment' session after the main morning surgery. The practice also offered telephone consultations and email consultations if requested by individual patients. The practice recognised that patients with complex care needs could deteriorate suddenly and need urgent appointments. When necessary they saw these patients outside practice hours.

Information from patients confirmed that appointments were readily available and that if needed they were seen on

Good

Are services responsive to people's needs?

(for example, to feedback?)

the same day. Patients could book appointments by telephone, in person at the practice or online. Patients also said they did not usually have to wait long at the practice before being seen.

In the January 2015 the NHS GP patient survey results showed that of the patients who responded -

- 95% found it easy to get through on the telephone (CCG average 79%; national average 73%).
- 94% described their experience of making and appointment as good (CCG average 79%; national average 73%).
- 92% were satisfied with the practice's opening hours (CCG average 76%; national average 75%).
- 93% were able to get an appointment or speak with someone the last time they tried (CCG average 89%; national average 85%).
- 87% of patients who preferred to see a particular GP were able to do so (CCG average 65%; national average 60%).
- 87% usually waited 15 minutes or less after their appointment time (CCG average 68%; national average 65%).

The practice leaflet, the website, and a poster in reception provided patients with information about a seven days a week extended hours service operated by Taurus Healthcare, a Herefordshire GP federation. This was established using funding granted by the Prime Minister's Challenge Fund. Patients were able to use this service between 6pm and 8pm on weekdays and 8am to 8pm at weekends and on bank holidays. The practice also provided information about the Hereford GP Access Centre which was operated by Primecare, a national healthcare provider. This was open between 8am and 8pm seven days a week.

The practice dispensary was open from 8am to 1.30pm and from 2pm to 6.30pm.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns. This was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person to manage complaints. The practice had a complaint form for staff to use if a patient raised a concern direct with them. There was clear information for patients about how to complain in the practice leaflet and on their website. Information was also available on a notice board at the practice; this included details of the Patient Advice and Liaison service.

Whilst the practice had received few complaints they analysed and reflected on any that patients made to contribute to learning and improvement. The practice described an approach that involved having good communication with patients so that concerns did not escalate to become formal complaints. The practice manager aimed to arrange to speak face to face with any patient who raised a concern within 24 hours. The practice had never had a complaint escalated to the Ombudsman and one complaint made to the Patient Advice and Liaison service was not upheld.

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 GP partners had a clear vision to continue to provide individualised care to the local community as the practice had done for many years. They recognised that they also needed to adapt and develop taking into account factors outside their control such as the possibility of additional local housing. The partners had a comprehensive structured business plan for 2014 to 2016. This included a three year plan covering a wide range of topics including consideration of succession planning, staff training and development, and the need to respond to political and economic factors. All the staff we spoke with were as committed to the future of the practice as the GP partners.

Governance arrangements

The practice had a range of policies and procedures relating to the management of the practice and these were reviewed and updated although we noted that reviews for a small number were overdue. Staff had direct access to these on the practice computer system. All the staff we met understood their roles and responsibilities within the practice.

The practice recognised that because half of the GPs were part time and did not all work on the same days it was important to ensure effective communication. Those at work met after morning surgery every day and the partners and practice manager met every Friday. There was a monthly business meeting.

All members of the practice team took part in full team meetings four times a year. These were used to discuss a range of topics such as new policies and procedures and to provide training including safeguarding and medicines updates.

Leadership, openness and transparency

The two GP partners and other members of the practice team had lead roles and responsibilities for various aspects of the operational and strategic management of the practice. The GP partners had appointed the new practice manager before the previous one had fully retired to provide an opportunity for a seamless handover.

The practice operated a 360 degree appraisal system which included feedback from patients. We saw an example of very positive feedback from a patient to one GP's appraisal.

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

The practice had a patient participation group (PPG), a group of patients registered with a practice who worked with the practice team to improve services and the quality of care. The group had been established for 18 months. The practice viewed the group as a sounding board for ideas and planned to use them more proactively to gather the views of patients. We spoke with a PPG representative during the inspection. They confirmed that the PPG had a positive relationship with the practice and that the partners asked them to suggest improvements. They told us the practice shared information with them about the actions and outcomes in response to complaints, comments and significant events.

The practice was aware of the results of the NHS GP patient survey and had implemented the NHS Friends and Family Test. They also completed their own patient surveys which reflected equally positive views.

The practice team told us they viewed every contact with a patient as an opportunity to learn and to assess and respond to patients' individual needs. There was a quarterly patient newsletter which was available at the practice and on the website. The practice had agreed the format with the PPG and sent members a personal copy.

The practice had a whistleblowing policy to inform staff of their rights should they need to raise concerns. Staff told us the GPs and management team were approachable and that they would be able to raise concerns if necessary. The practice management team aimed to use team meetings as opportunities for staff to share their ideas and suggest improvements.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their continuous professional development through appraisal and training. The practice supported members of the practice team to develop their knowledge and skills. This included providing clinical staff with five days a year protected learning time.

Are services well-led?

Good

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

The practice used reviews of significant events and other incidents to identify areas for learning and improvement. Actions and outcomes from significant events and complaints were shared with staff at practice meetings to help the practice improve outcomes for patients.

The practice provided work experience placements for sixth form students who might be considering a career in medicine or nursing. The practice provided a formal induction session for these students. This covered topics such as confidentiality and fire procedures. They signed a confidentiality agreement and were supervised at all times. They attended consultations with consent from patients.

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 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The practice did not have effective systems to assess, monitor and mitigate the risks relating to the health, safety and welfare of patients, staff and visitors. · They had not regularly audited infection prevention and control arrangements at the practice in line with national guidance. · They did not have arrangements for calibrating equipment used for patient care. · Some policies and procedures had not been reviewed to ensure they reflect current legislation and national guidance. Regulation 17 (1)(2)(b)