Dr Michael John Heber

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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr Michael John Heber on 3 November 2015. Overall the practice is rated as outstanding.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. There were monthly multidisciplinary meetings. The practice had used software to identify patients with conditions which might otherwise have been missed.
- Feedback from patients about their care was positive and was consistently significantly better than local and national feedback.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet people's needs. For example in their professional interactions with a local nursing home and the local independent school.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example in the way that services were made available to members of the traveller community.
- 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
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

Summary of findings

There was an area of practice where the provider should make improvements:

- The practice should check and reconcile the controlled drugs register

We saw several areas of outstanding practice including:

- The GP was available to staff from the local nursing home both out of hours and at weekends for advice on avoiding admission to hospital or end of life care.
- GPs gave their personal contact telephone numbers to patients who were dying at home and were contactable in the event of a crisis.
- The practice used a wide range of information and specialist software to review the effectiveness of its care and treatment.
- The practice had written up several anonymised cases where patients, who wished to die at home, had been supported to do so. These had been presented as significant events so as to share best practice.
- Data showed that patients rated the practice higher, for the caring and the responsive aspects of its services, than all the local and national averages.
- Governance and performance management arrangements were under constant review. The practice actively sought out and used data from wide range of sources.
- The practice had proactively recruited patients to the patient participation group so that it was truly representative of the practice demographic.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

All the GPs and nurses were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines and there were systems to help ensure that they remained so. There was evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. For example by changes in prescribing practice from higher to lower risk painkillers and by work to identify and educate patients who were pre disposed to diabetes so as to mitigate the effects of the disease.

The patient outcomes for the practice were high when compared to neighbouring practices in the Clinical Commissioning Group.

The practice used a wide range of information to review the effectiveness of its care and treatment. The practice benchmarked itself against local practices and from this had identified areas for improvement such as a reduction in the prescribing of high risk antibiotics.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

Data showed that patients rated the practice higher than others for all aspects of care. In the most recent independent poll of patients the practice results for all questions relating to caring were substantially better than the local and national results.

Feedback from patients about their care and treatment was consistently and strongly positive. One third of the comments cards we received specifically mentioned the caring attitude of staff.

We observed a strong patient-centred culture. Receptionists knew the patients well. Patients told us there was a homely feel to the practice.

Summary of findings

Staff were motivated and inspired to offer kind and compassionate care, for example reception staff told us they would ring vulnerable patients or those with young children if their appointments were running late so that they would not spend excessive time in the waiting room.

In cases of end of life care the GPs provided dedicated telephone numbers to the families so that they could be reached in the event of a crisis.

We talked to staff at a local nursing home and the local boarding school and their views were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding ☆

The practice is rated as outstanding for providing responsive services.

It 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 the practice secured the return of antenatal service to the practice after they had been moved elsewhere.

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. In the most recent independent poll of patients the practice results scored extremely highly for continuity of care and access to services. 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 that the practice responded quickly to issues raised. Explanations and apologies were tendered when appropriate. Learning from complaints was shared with staff and other stakeholders. There was a monthly meeting with a neighbouring practice where learning events and local trends were discussed.

Are services well-led?

Outstanding ☆

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

It had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with staff and patients. It was regularly reviewed and discussed with staff.

High standards were promoted and owned by all practice staff. There was a very low staff turnover with a well-established team where staff worked across all roles.

Summary of findings

Governance and performance management arrangements were under constant review. The practice actively sought out and used data from wide range of sources, for example it had commissioned its own surveys and purchased specialist software to support providing the safest and effective care for patients.

The practice carried out succession planning and this had led to a recent change in the practice structure.

Staff were engaged in their roles and there was a high level of staff satisfaction. There were regular practice team and social events.

The practice gathered feedback from patients using their website and surveys. There was a very active patient participation group. The practice had proactively recruited patients so the group was representative of the practice demographic, including school age patients, carers, the disabled and the traveller community. The group had financed a number of improvements to practice.

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

Outstanding ☆

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of older patients.

The practice offered proactive, personalised care to meet the needs of older patients. It looked after 25 high dependency beds at the local nursing home. Staff there had the GPs telephone number and were able to contact the GP at weekends to discuss end of life care or measures to prevent admission to hospital where this was appropriate. All the patients at the home have detailed care plans with an emphasis on avoiding unplanned admission to hospital.

There were monthly integrated care meetings involving health and social care which supported information sharing about vulnerable, elderly or housebound patients. In many practices these meetings are held every three months. GPs gave their personal contact telephone numbers to patients who were dying at home and were contactable in the event of a crisis.

Repeat prescriptions were available over the telephone for older or housebound patients, who did not have, or who were not confident in using, the on-line repeat service.

It was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs. Two staff members visited the housebound elderly to administer influenza vaccinations.

People with long term conditions

Outstanding ☆

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of patients with long-term conditions.

The practice is rated as outstanding for the care of patients with long-term conditions. Such patients had a named GP and a structured annual review to check that their health and medicines needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The patient outcomes for the practice were high when compared to neighbouring practices in the Clinical Commissioning Group. In 17 of 19 common conditions the practice had achieved 100% of the clinical measures regarded as best practice for the treatment of

those conditions. Diabetic admissions and complications were lower than the average for the locality. GPs identified patients at risk of hospital admission as a priority. The practice had lower than average admission to Accident and Emergency (A&E) across all these areas

The practice had used specialist software to review patient care, as a result patients had been identified with long term conditions who might otherwise have been missed. There had been no diagnoses of patients with cancer made in A&E, nationally about a quarter of such patients were diagnosed in A&E.

Longer appointments and home visits were available when needed.

Families, children and young people

Outstanding ☆

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of families, children and young people.

There were systems 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 90% or more for all standard childhood immunisations. This was despite the fact that there was a substantial proportion of children from the traveller community who are historically difficult to reach with these services. Where families missed an appointment for a vaccination the practice followed this up by telephone.

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice had negotiated the return of antenatal clinics to the practice, a service much valued by the affected patients. The practice had bettered the national and local results for the cervical cancer screening programme on average over the last decade.

The practice served the needs of boarders at a nearby school, there was drop in-clinic weekly and access to emergency contraception, for patients registered at the practice and others who were not. Both GPs had included adolescent learning modules in their recent training. There were GPs trained in family planning and reproductive healthcare and competent in coil insertion.

There was an adolescent patient as a member of the patient participation group.

Summary of findings

Working age people (including those recently retired and students)

Outstanding ☆

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding 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 had developed a “one stop shop” for diabetic patients that reduced the number of appointments those patients needed to attend. This impacted particularly on working age patients.

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

People whose circumstances may make them vulnerable

Outstanding ☆

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of patients whose circumstances may make them vulnerable

The practice held a register of patients living in vulnerable circumstances such as those from the traveller community or those with a learning disability.

There was a representative from the traveller community on the patient participation group, who had been very active in improving understanding about the needs of that community. The practice responded to these needs by being readily available to see patients without a previous appointment particularly at the beginning or end of the sessions.

It had carried out annual health checks for all patients with a learning disability. It offered longer appointments for people with a learning disability. The practice identified that there were a number of East European farm workers registered with them and had translation services available if needed.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

People experiencing poor mental health (including people with dementia)

Outstanding

The factors that led to the practice being rated as outstanding overall applied to all the population groups, therefore the practice is rated as outstanding for the care of patients experiencing poor mental health (including people with dementia).

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 raised its rate of diagnosis of dementia to one of the highest levels in the local clinical commissioning group after recognising that its performance had been weak in this area. Thirteen out of 16 patients (81%) had had their care reviewed in a face to face consultation. In four of the last eight years this had been 100% of patients. All the staff at the practice had become “dementia friends”, learning more about the condition and how to help patients and their families struggling with it.

In 2014 and in 2015 94% of mental health patients had a care plan, agreed between them, their family and/or carers as appropriate and the GP. Between 2007 and 2013 the percentage of patients with such a care plan had been better than both the national and local averages by between 7% and 15%.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.

There was a patient with a long term mental health condition on the practice’s patient participation group.

Summary of findings

What people who use the service say

The national GP patient survey results showed the practice was performing considerably better than local and national averages.

- 99% find it easy to get through to this surgery by phone compared with a clinical commissioning group (CCG) average of 75% and a national average of 73%.
- 95% find the receptionists at this surgery helpful compared with a CCG average of 88% and a national average of 87%.
- 85% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 72% and a national average of 60%.
- 96% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88% and a national average of 85%.
- 99% say the last appointment they got was convenient compared with a CCG average of 93% and a national average of 92%.
- 97% describe their experience of making an appointment as good compared with a CCG average of 78% and a national average of 73%.
- 96% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 64% and a national average of 65%.
- 94% feel they don't normally have to wait too long to be seen compared with a CCG and national average of 58%.

As part of our inspection we asked patients to complete comment cards provided by the CQC. We received 39 comment cards which were all positive about the standard of care received. The themes that ran through the comments were; the helpfulness of reception staff and ease of obtaining appointments, the cleanliness of the premises and GPs and nurses received praise for their clinical skills in diagnosing and treating conditions.

Areas for improvement

Action the service SHOULD take to improve

The practice should check and reconcile the controlled drugs register.

Outstanding practice

We saw several areas of outstanding practice including:

- The GP was available to staff from the local nursing home both out of hours and at weekends for advice on avoiding admission to hospital or end of life care.
- GPs gave their personal contact telephone numbers to patients who were dying at home and were contactable in the event of a crisis.
- The practice used a wide range of information and specialist software to review the effectiveness of its care and treatment.
- The practice had written up several anonymised cases where patients, who wished to die at home, had been supported to do so. These had been presented as significant events so as to share best practice.
- Data showed that patients rated the practice higher, for the caring and the responsive aspects of its services, than all the local and national averages.
- Governance and performance management arrangements were under constant review. The practice actively sought out and used data from wide range of sources.
- The practice had proactively recruited patients to the patient participation group so that it was truly representative of the practice demographic.

Dr Michael John Heber

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 second CQC inspector, a pharmacy specialist advisor and a practice manager specialist advisor.

Background to Dr Michael John Heber

Dr Michael John Heber, also known as the Cobtree Medical Practice is a GP practice located in the village of Sutton Valance Kent. It provides care for approximately 2500 patients. The practice is in a rural area.

There are two GP partners and a retained GP, one male and two female. There are two practice nurses, both female, one being a regular locum nurse.

The age of the population the practice serves is close to the national averages. There are marginally more young people (aged less than 18 years) and slightly more older people (aged over 64 years). Income deprivation and unemployment are low being about half and one sixth of the national figures respectively. About five percent of the practice's patients come from the traveller community.

The practice has a general medical services contract with NHS England for delivering primary care services to local communities. The practice offers a full range of primary medical services and is able to provide pharmaceutical services to those patients on the practice list who live more than one mile (1.6km) from their nearest pharmacy premises. The practice is not a training practice.

The practice is open between 8am and 6.30pm Monday to Friday. There is an evening surgery until 7.45pm on Tuesdays. Appointments are from 9am to 1pm and 2.15pm until 5.30pm.

The surgery building is a converted detached house with consulting and treatment rooms on the ground floor and administrative rooms upstairs.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by Integrated Care 24**.** There is information, on the practice building and website, for patients on how to access the out of hours service when the practice is closed.

Why we carried out this inspection

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

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 visiting, we reviewed a range of information we hold about the practice. This included demographic data,

Detailed findings

results of surveys and data from the Quality and Outcomes Framework (QOF). QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice.

We asked the local clinical commissioning group (CCG), NHS England and the local Healthwatch to share what they knew about the service.

The visit was announced and we placed comment cards in the practice reception so that patients could share their views and experiences of the service before and during the inspection visit. We carried out an announced visit on 3 November 2015. During our visit we spoke with a range of staff including two partner GPs, a practice nurse, the practice manager, receptionists and administrators. We spoke with patients who used the service. We spoke with nursing staff at a nearby independent school where many of the boarding pupils were registered with the practice. We spoke with the manager of a local nursing home where the practice has responsibility for 25 high dependency beds.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

Staff told us they would inform the practice manager of any incidents and there was a standard form for recording events. The practice analysed the significant events to identify trends and learn lessons. The practice had developed a "could do better" form for incidents which were not sufficiently serious so as to be classed as significant events but from which lessons might be learned. We saw that learning from this was discussed at staff meetings.

We reviewed safety records, incident reports national 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 we saw an incident that involved a significant dispensing error. Actions arising from the investigation included the updating of standard operating procedures, a review of dispensing staff training and a system to double check all dispensed items.

We saw that the patient in this case received both verbal and written apologies, the appropriate support and was told about the outcome of the practice's investigation.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices to help keep people safe.

There were arrangements to safeguard adults and children from abuse that reflected relevant legislation and local requirements. Policies, and notices at strategic points within the building, showed who to contact for further guidance if staff had concerns about patients' welfare. Staff told us of examples where matters had been reported to and investigated by the appropriate authorities. All GPs were trained in child safeguarding to level three, nursing staff and healthcare assistants were trained to level two. Administrative staff were also trained to level two though the mandatory level required was level one. The practice felt that the administrative staff needed the higher level of training because of their frequent interaction with the public.

There were notices in the waiting room and in consultation rooms, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones had received a disclosure and barring check (DBS). These 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 vulnerable adults.

The practice maintained high standards of cleanliness and hygiene. We observed the premises to be clean and tidy. Patients we spoke with said that they had no concerns about cleanliness or infection control. The building was a converted house and this made some areas of infection control more difficult. The practice had recognised this and there was a long term plan to refurbish the clinical areas to reflect the latest standards. We saw some of this work had already been done for example there had been improvements to the seating in the waiting area. The practice nurse was the infection control clinical lead and they were up to date with the most recent best practice and were able to provide training, for example in hand washing techniques, and advice.

Medicines in the treatment rooms, the dispensary and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy to help ensure that medicines were kept at the required temperatures and which described the action to take in the event of a power failure. Temperatures were checked and recorded in accordance with the practice processes.

Regular medication and prescribing reviews were carried out with the support of the clinical commissioning group (CCG) help to ensure the practice was prescribing in line with best practice guidelines. Prescription were checked and signed by GPs before medicines were given to patients.

Repeat prescriptions were received electronically or by hand at the practice. Repeat prescriptions for elderly patients, who had difficulty in attending the practice, were accepted over the telephone. The practice acknowledged that this was a risk but had audited the arrangements and no mistakes had been found. There was an additional software tool used by the practice to identify when patients, who were prescribed specific medicines which required particular safety checks, had not had those checks. These patients were then followed up to help to ensure that their medicines were being safely administered.

Good

Are services safe?

We checked the controlled drugs register and found that there had been some transcription errors when the practice had moved from an older to a newer register. The practice should check and correct the register.

Prescription pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines and vaccines in line with legislation.

We reviewed four staff files and found that 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.

Monitoring risks to patients

There were processes for monitoring and managing risks to patients and staff. For example, there had been a recent fire risk assessment and fire wardens had been trained and appointed. There was a system governing security of the practice with visitors required to sign in and out using the dedicated book in reception. The staff reception area in the waiting room was always occupied when patients were in the building. Electrical equipment had been tested for safety and equipment which needed regular calibration had been calibrated. There were assessments for other risks such as for the control of substances hazardous to health and legionella.

The number of staff needed to provide the required services had been assessed by the practice and a rota developed to meet those needs. During times of greater demand the practice had increased the numbers of clinical sessions to meet it.

Arrangements to deal with emergencies and major incidents

All staff received annual basic life support training and there were emergency medicines available in the treatment room. There were further emergency medicines in the GPs bags. The emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Emergency medicines we looked at were in date and checked regularly together with the emergency equipment. The practice had a defibrillator and medical oxygen with adult and children's masks.

There was a business continuity plan to deal with a range of emergencies such as power failure, adverse weather, unplanned sickness and access to the building. The plan had been reviewed annually and contained current contact numbers for the various agencies who might need to be contacted in the event of an emergency. Key staff members had a copy of the plan at their home address in the event that the building could not be accessed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with the National Institute of Health and Care Excellence (NICE) guidelines and had systems to ensure GPs and nurses were kept up to date. The practice had access to guidelines from NICE and guidelines about other local practice such as local referral pathways. The practice used the guidelines, for example by using ambulatory blood pressure monitoring for the diagnosis of patients where hypertension (raised blood pressure) was suspected. The practice considered local guidelines such as the Clinical Commissioning Group (CCG) guidance in respect of impaired glucose regulation.

New guidance was discussed at meetings. The practice monitored that guidelines were followed through audits, checking of patient records and review of the practice's performance across specific diseases and conditions.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF), NHS England High level GP indicators, local data 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).

QOF results cover the practice's performance in 19 clinical areas ranging from asthma to stroke. In 17 of the 19 areas the practice achieved 100% of the available clinical indicators.

Only in asthma and diabetes did the practice fail to achieve 100%. The practice had identified that their results for the diabetic management were not as good as they expected. They had conducted an audit, reviewed their referrals to secondary care and their treatment plans. As a result, whilst the practice recognised there is more work to do, it currently achieved 87% of the diabetic indicators. Using similar approach, to asthma management, the practice currently achieved 91% of the relevant indicators.

QOF exception reporting was in line with or below national levels on the practice average being two thirds of the national and local average. Overall the practice achieved 423 out of 435 clinical QOF points that is 97% in total.

Other audits and results supported this achievement. For example an audit of the practice's cancer diagnosis showed that none of the patients had had cancer first diagnosed in Accident and Emergency. The National Cancer Intelligence Network study indicates that the diagnosis of cancer in hospitals ranges from 31% (over 70s) to 24% (all ages). Emergency cancer admissions per 100 patients on disease register was 0.16 as opposed to 7.4 nationally.

The practice benchmarked itself against local practices and from this had identified areas for improvement such as a reduction in the prescribing of high risk antibiotics. The practice prescribing of high risk antibiotics was consistently the lowest of the local practices and was between half and one third of that prescribed nationally.

Clinical audits demonstrated quality improvement. During the current year the practice had undertaken nine audits. Four of these were clinical audits involving medicines such as injectable contraception, treatment of heart conditions and novel oral anticoagulants. The findings were used to improve outcomes for patients. For example women receiving the injectable contraception now have a marker placed on their records to help ensure that their reviews are carried out within a specific timespan. The audits also showed that locums were not as aware as partners of some the issues identified by audit and this has been addressed though discussion and training.

There were five administrative audits focused on safety issues such as infection prevention control and telephone repeat prescribing for elderly patients. The practice developed action plans from them and these had led to improvements in services.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment. There was a training plan and mandatory training such as information governance, basic life support and infection prevention control had been completed by all staff. There was an induction process for new staff to help enable them work within local polies conditions.

There was role-specific training and updating for relevant staff such as refresher training for the practice nurse in the management of diabetes, in administering vaccinations and taking samples for the cervical screening programme.

Good

Are services effective?

(for example, treatment is effective)

The diabetic audit had resulted in further training in diabetic management for the practice nurse and one of the GPs had the management of difficult diabetic cases as a personal development objective for the forthcoming year.

Staff training needs were identified through appraisals, meetings and reviews of practice needs. Staff had received training to meet those learning needs or there were plans for them to do so. For example one of the practice nurses planned to undertake specialist training in supporting patients with long term conditions.

All staff had had an annual appraisal and all the staff we spoke with about their appraisal said that they had found the process useful. They confirmed that the process had been used it to identify training needs and it provided an opportunity for staff to discuss their performance with their manager. All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation.

Coordinating patient care and information sharing

The practice worked with other service providers to meet patients' needs. It received blood test results, X ray results, and other correspondence both electronically, by fax and by post. Staff knew their responsibilities in dealing with any issues arising from these communications. The results were regularly checked and there were systems to help ensure that there were staff available to check results when other staff were absent.

Staff worked together and with other health and social care services to understand and meet the range and complexity of people's needs and to assess and plan their care and treatment. This included when people moved between services. The practice met monthly with other services in multi-disciplinary teams to manage the care of the more complex cases. These meeting included staff from the local and district nursing care teams and the health and social care co-ordinators.

Consent to care and treatment

The practice had a consent policy that governed the process of consent and provided guidance for staff. The policy described the various ways patients were able to give their consent to examination, care and treatment, as well as how consent should be recorded. For example, specific consent forms for surgical procedures were used and scanned onto the patient's record.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. We saw several instances where this legislation had been applied constructively. There were audits of records to demonstrate that consent requirements were met.

Health promotion and prevention

The practice identified patients who may be in need of extra support. These included patients who needed palliative care and those who were likely to be have an unplanned admission to hospital. There was a proactive approach to disease prevention. For example the practice was actively looking for patients with pre diabetes with a view to reviewing them annually and offering support to mitigate the onset of the disease.

Cervical screening was effective with 83% of relevant patients undertaking the test in the current year this is in line with national results. Performance over the past ten years has been better than that locally and nationally.

Childhood immunisations for the practice were over 90% for all two and five year olds, despite there being a substantial traveller community who, evidence suggests, are difficult to reach with these services. When children missed an immunisation the practice telephoned the family to follow up on the non- attendance. Influenza immunisation amongst those over 64 years old was marginally better than that nationally. The practice and the patient participation group had organised a "tea party" to encourage attendance and reported that this had improved the uptake. For example the percentage of diabetic patients who had taken advantage of the influenza immunisation had risen from 91% to 97%.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed that the reception staff were courteous and very helpful to patients and treated them with dignity and respect.

Patient confidentiality was respected. There was a private area where patients could talk to staff if they wished. The waiting room and reception desk area was open plan and very welcoming but this did make it difficult for staff to maintain confidential discussions with patients. Staff were aware of this and took account of it their dealings with patients. Patients were kept informed by staff if any of the GP consultations were running late. Staff told us they knew patients well and for elderly, vulnerable or patients bringing children to the practice, they would telephone them at home when GPs were delayed so that the patients would not have to wait so long to be seen.

All consultations and treatments were carried out in the privacy of a consulting room. We saw that staff always knocked and waited for a reply before entering any consulting or treatment rooms and it was not possible to overhear what was being said in them. The rooms were, where necessary, fitted with window blinds. The consulting couches had curtains and patients said that the GPs and nurses closed them when this was necessary.

There were 39 comment cards left by patients, of these 13 specifically mentioned the care and compassion with which reception staff treated them. Patients said the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. There were no negative comments.

We also spoke with four members 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 patients needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The poll comprised 242 questionnaires sent out and 120 returned, this was 5% of the practice list. The practice results were significantly better than those locally or nationally for its satisfaction scores on consultations with doctors and nurses and interaction with reception staff. The survey results showed that:

- 98% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and national average of 89%.When asked the same question about nursing staff 96% said the nurses were good at listening to them compared to the CCG average of 93% and national average of 91%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%.When asked the same question about nursing staff 99% said they had confidence and trust in the last nurse they saw were good at listening to them compared to the CCG average of 98% and national average of 97%.
- 95% said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us in interview and on comment cards that they felt involved in decision making about the care and treatment they received. They 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.

The patient survey information showed patients responded positively to questions about their involvement in planning and making decisions about their care as well as treatment. The practice results were exceptionally better than those nationally. Data from the national patient survey showed that:

- 98% said the GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.When asked the same question about nursing staff 95% were positive about the nursing staff compared to the CCG average of 92% and national average of 90%.
- 98% said the GP they saw was good at involving them in decisions about their care compared to the CCG average

Are services caring?

of 84% and national average of 81%.When asked the same question about nursing staff 94% were positive about the nursing staff compared to the CCG average of 87% and national average of 85%.

- 99% said the GP the GP gave them enough time compared to the CCG average of 88% and national average of 87%.When asked the same question about nursing staff 97% said the nurses were good at listening to them compared to the CCG average of 94% and national average of 92%.

The practice was responsible for 25 high dependency beds at a local nursing home. Despite the fact that the Visiting Medical Officer scheme was no longer funded the practice had maintained their level of care. There was a weekly ward round and visits as needed on the day. Nursing staff at the home had a bypass telephone number for the practice so that they could access GP and nursing advice without delay. The GP was available to staff both out of hours and at weekends for advice on avoiding admission to hospital or end of life care.

Translation services were available for patients who needed them and there were notices in the reception to this effect.

Patient and carer support to cope emotionally with care and treatment

There was support and information provided to patients and their carers to help them cope emotionally with their care, treatment or condition. We heard staff explaining to patients how they could access services such as those related to specific disabilities. Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice had a register of patients who were carers or who had a carer. There was a “carer’s corner” in part of the waiting room. This provided details of support services, such as access to respite care, and local services such as the local voluntary car service. This service, which the practice encouraged and supported provided transport for patients in the rural community to help them access services. Some patients who might otherwise have had to be seen at home were able to come to the practice. We spoke with patients who appreciated this service not simply because it helped them the come to the practice but because it helped to reduce a sense of isolation.

The practice has a small number of palliative care patients. Their individual care was discussed monthly at a multi-disciplinary meeting. We saw several anonymised cases where patients, who wished to die at home, had been supported to do so. These had been written up and presented as significant events so as to share best practice. GPs gave their personal contact telephone numbers to patients who were dying at home and we were told that this was appreciated.

Where families had suffered bereavement, their usual GP contacted telephone them to offer their sympathy and the offer of a consultation at a flexible time and location to meet the family’s needs.

Outstanding ☆

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 the practice had had regular antenatal clinics and a practice midwife, these services were valued by patients. The services were moved elsewhere because of resource issues. The practice negotiated their return through timely and articulate protest.

There was a "commuter's clinic" on Tuesday evenings for working patients who found it difficult to attend during working hours. During the period under review the practice had provided a home visiting service and annual health checks for a learning disability home. During that time all the people in the home had had annual health checks.

Home visits were available for older patients or patients who would benefit from them. There were longer appointments available for patients who needed them, for example patients with dementia or learning disability. Same day appointments were available for children and those with serious medical conditions.

About five per cent of the practice population came from the traveller community. That community had a representative on the on the Practice Participation Group. Through involving that person the practice had learned of the issues facing this group had, for example from both literacy difficulty and cultural preference, in making pre-booked appointments. The practice made itself readily available to patients from that community by seeing them at short, or no, notice, generally at the beginning or end of the sessions.

There is a large private school within the practice boundaries. To provide for this group there was a weekly drop in clinic at the school medical centre. Older children were able to consult the practice independently. The practice provided emergency contraception to people whether they were on the practice list or not. Reception staff had standing instructions to respond promptly to any teenager asking for any emergency appointment.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. Extended hours surgeries were offered on Tuesday evenings until 7.45pm. In addition to pre-bookable appointments, to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment exceptionally exceeded local and national averages.

- 94% of patients were satisfied with the practice's opening hours compared to the CCG average of 74% and national average of 75%.
- 99% patients said they could get through easily to the surgery by phone compared to the CCG average of 80% and national average of 73%.
- 96% patients said they could get an appointment when they needed one compared to the CCG average of 88% and national average of 85%, 97% said that their experience of making an appointment was good compared to the CCG average of 78% and national average of 73%.
- Patients saw the GP they wanted to and on time; 85% patients said they saw their GP of choice compared to the CCG average of 72% and national average of 60%, 94% patients feel they don't normally have to wait too long compared to the CCG and national average of 58%.

The patient comment cards supported these findings with 17 out of 39 responses specifically mentioning the ease of obtaining appointments.

Listening and learning from concerns and complaints

There was a complaints policy which included timescales by which a complainant could expect to receive a reply. The longest serving partner was designated to manage complaints. Information was available to help patients understand the complaints system in the form of leaflets, notices and material on the website.

We looked at the two complaints received in the last 12 months and found that they had been handled in accordance with the practice's policy. The practice found that one complaint was substantiated and, in addition, treated it as a significant event. The patient was kept informed of the practice's investigation, verbally and in writing. A sincere and complete apology was offered in a

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

timely fashion. The patient elected to remain on the practice's list. The second complaint was not substantiated but the patient was offered a place on the practice list when they asked for it.

Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, there had been changes to training, supervision and policies as a result of the first complaint.

Are services well-led?

Outstanding ☆

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

Our findings

Vision and strategy

The practice's mission, vision and values were set out in a statement of purpose. All the staff we spoke with were aware of the vision and what it meant for them. The mission statement included working with patients, the local community and partners to achieve the best outcomes for patients.

There were a number of plans to monitor performance against the vision including an overarching development plan for the practice and several action plans resulting from audits and patient surveys. For example as part of a planned approach to succession planning the practice had moved from being a sole practitioner to a two GP partnership.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care.

There were practice specific policies that were available to all staff. There was evidence that the policies had been read by staff. We looked at some of these including recruitment, chaperoning, safeguarding, bereavement and complaints they were in date and reviewed when necessary.

There was no "senior" partner as such. Leadership in the practice fell equally to both partners and the practice manager. There were however clear leadership roles for named members of staff. For example, there was a lead nurse for infection control, a GP with responsibility for safeguarding and a lead for performance against the quality and outcomes framework (QOF) and other outcome measures. There was a comprehensive understanding of the performance of the practice.

There was regular review of the practice performance against:

- NHS England data (GP outcomes)
- QOF
- Local Clinical Commissioning Group (CCG) data
- Eclipse data (this is a real time one-line tool for bench marking in long term conditions)
- Medicines optimisation scheme (MOS)
- Referrals data
- Audits
- Significant events and/or complaints

We looked at a range of reports resulting from the reviews. In each area the practice had noted the positive outcomes for patients and acted in areas which had been identified for improvement. For example:

- Two staff members visited the housebound elderly to administer influenza vaccinations. The practice saw that these had been late the previous year because of pressures on the district nursing team.
- A "one stop shop" for diabetics, particularly those of working age. Retinal screening and blood tests were done on the same day with a telephone follow up for the results. This reduced (a possible) four appointments to one.
- The practice use of Eclipse data directly led to the identification of two cases of an untreated disease which might otherwise not have been identified. It led to the practice changing prescribing for painkillers from a higher risk to a lower risk medicine.
- The MOS had resulted in an audit that evidenced that patients on particular (non-generic) medicines used for erectile dysfunction were receiving medicines that were safe for them.
- Referrals data showed that there was an improvement in patient choice through the use of "Choose and Book" (this a national electronic referral service which gives patients a choice of place, date and time for their appointment in a hospital or clinic).

The practice's commitment to the positive use of Eclipse data had been commented on by the CCG.

The practice was accredited by the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. The DSQS provided an addition layer of governance in respect of practices dispensing medicines.

The practice held a monthly meeting with a neighbouring practice to share best practice, concerns and local trends.

Leadership, openness and transparency

The partners and the practice manager were visible and it was clear that there was an open culture within the practice. Staff had the opportunity to and were happy to raise issues at team meetings. Staff told us that the GPs and management were approachable and took the time to listen.

Are services well-led?

Outstanding ☆

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

The practice was aware of and complied with the requirements of the Duty of Candour. We saw the report of an incident that acknowledged that, had the incident happened a few months later, it would have been subject to a Duty of Candour. The practice therefore treated it as such. The partners encouraged a culture of openness and honesty. The same safety incident evidenced that patients were provided with support, truthful information and a verbal and written apology. Both the verbal and written interaction were documented.

Staff felt very well supported by management. There were regular practice meetings. Minutes were kept and there was a structured agenda. The range of meetings encompassed full staff meetings, significant events, palliative care and weekly meetings with the community nursing teams. We saw from minutes that all staff regularly contributed to how the practice developed. Staff told us of occasions when they had made suggestions at staff meetings such as changes to working practices. The changes had been accepted or, where this was not possible, staff were told why.

There were practice team building days or social events, paid for by the practice, approximately six times a year. Staff told us that this helped to break down barriers and made it easier to speak freely, particularly about sensitive issues. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. Patients were asked to provide feedback through the practice's website, through the patient participation group (PPG) and through in house and other surveys such as the Improving Practice Questionnaire.

There was an active PPG which met on a regular basis, carried out patient surveys and submitted proposals for improvements to the practice management team. The practice had examined the patient demographic and proactively recruited PPG members to represent this. There was a member of the travelling community, a disabled individual, a carer and patient of school age. The PPG was chaired by a patient with business experience. There had been advantages for the patients from this. For example a relatively high number of children from the travelling community, often difficult to reach, had received the standard immunisations. Other initiatives, developed and paid for by, the PPG were the "carer's corner" in the waiting room, the installation of a wall mounted magazine rack to help elderly patients and those with a back problem and the installation of a hearing loop.

There had been patient surveys sponsored by the practice, but conducted independently, in 2012, 2014 and 2015. These were in addition to the National Patient Survey and had shown high levels of satisfaction with the practice. Action plans had been developed from the results of the surveys. Improvements that had flowed from this included the development of new technologies such as on-line booking and when to offer extended hours and for how long.

Continuous improvement

There was a strong focus on continuous learning and improvement at all levels within the practice. One GP was an examiner for the Royal College of General Practitioners and a senior appraiser for GPs in the area. Both these roles entailed being conversant with recent best practice and developments in general practice. The practice had hosted Foundation year 2 doctors until 2015. Currently the practice hosts student nurse placements as part of the Primary Care Education Network. The practice nurse had recently completed their mentoring training to support placements.

In response to the issues the practice had identified concerning the care of diabetic patients, both GPs were undertaking specialised training and a practice nurse was undergoing a nationally recognised educational course in diabetic management.

The practice team was forward thinking and took part of local pilot schemes to improve outcomes for patients in the area such as the medicines optimisation scheme and a scheme to help identify and educate patients who were pre-diabetic so as to mitigate the effects of the condition.

The practice had responsibility for a number of children who were boarders at a nearby school because of this both GPs had undertaken specialist positive training in managing adolescent patients.