Magnolia House

Quality Report

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Date of inspection visit: To Be Confirmed
Date of publication: 22/01/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We undertook a comprehensive inspection of Magnolia House general practice on 22 October 2014. We have rated the overall practice as good. We found the safe domain was rated as requires improvement and the effective, caring, responsive and well led domains were rated as good.

Our key findings were as follows:

The practice is rated as requires improvement for safety. We found one of the treatment rooms did not have appropriate facilities. There was no risk assessment in place on the potential risks this treatment room placed on patients and how these risks were to be managed. Systems were in place for reporting and responding to safety incidents and alerts. The practice had a system in place for reporting, recording and monitoring significant events.

Generally the feedback from patients was very positive. Patient were complimentary of all the staff and described them has friendly, respectful, caring and thoughtful. Patients were very happy with the service they received.

We found the service was responsive to patient's needs. Patients we spoke with were generally happy with the appointment system. The national GP patient survey 2013 showed 84% of patients said they were able to get an appointment when they last tried. Eighty seven per cent patients described their overall experience of the practice as good. Overall 79% of patients said they would recommend the practice to someone new to the area.

Patients' needs were assessed and care and was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and further training needs had been identified and planned. The practice was well led, and had a clear vision and strategy. The practice had a clear leadership structure and staff we spoke with felt supported and valued.

The practice is a GP training practice.

Summary of findings

There were areas of the practice where the provider needs to make improvements

The practice MUST

- Ensure all treatment rooms have appropriate facilities to ensure safe delivery of care. Carry out a risk assessment for one of the treatment rooms to ensure it is fit for purpose.

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 safety as there were areas where improvements should be made. We found one of the treatment rooms did not have appropriate facilities. There was no risk assessment in place on the potential risks this treatment room placed on patients and how these risks were to be managed. Systems were in place for reporting and responding to safety incidents and alerts. The practice had a system in place for reporting, recording and monitoring significant events. Significant events, incidents and complaints were investigated and reflected on by the GPs and the senior management team during regular clinical meetings. The practice had comprehensive safeguarding policies and procedures in place to protect vulnerable patients. Patients we spoke with told us felt safe at the practice. The practice had management of medicines policies and procedures and staff knew how to access these. We found all medicines and vaccines stored were within expiry date and there were appropriate stock levels. The practice had safe systems and procedures were in place to deal with emergencies.

Are services effective?

Good

The practice is rated as good for effective. Patients had their needs assessed and care planned in accordance to best practice. The practice referred patients appropriately to secondary and other community care services. The practice routinely collects information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. The practice carried out regular clinical audits, and any improvement identified an action plan was devised and appropriate action was taken. Learning was shared and discussed with the GPs and nurses during team meetings. The practice had systems in place to monitor staff training. Staffing levels were frequently reviewed by the practice manager, to ensure they had enough staff members with appropriate skills.

Are services caring?

Good

The practice is rated as good for caring. Systems were in place to ensure patient privacy and dignity was maintained. Patients we spoke with told us they were treated with privacy, dignity and compassion. Patients were sufficiently involved in decisions about their care and treatment they received. Patients told us they felt

Summary of findings

listened to and supported by staff. Patients had access to health information. The practice patient participation group (PPG) organised regular health meetings, where various health topics were discussed.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice was responsive to patients needs and had sustainable systems in place to maintain the level of service provided. The practice used the risk stratification tool, which enabled them to profile patients by allocating a risk score dependent on the complexity of their disease type. Patients benefited from a stable staff team and there was good continuity of care and accessibility to appointments with a GP of choice. A range of clinics and services were offered to patients, which included family planning, antenatal, children's immunisation and minor illness. The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients, their families care and support needs. The practice had systems in place with hospital services to ensure information was available when a patient referral was made or once results where available.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice computer system. The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed they were performing in line with national standards. Staff told us they felt there was an open culture at the practice and they felt valued and well supported. The practice had a clear leadership structure which had named members of staff in lead roles. The practice had systems in place to seek and act on feedback from its patients, the public and staff. The practice had active patient participation group (PPG) who were involved in decision about the running of the practice. We found systems were in place for staff to access to learning and improvement opportunities. The practice was a GP training practice and completed self-assessments to confirm their ongoing suitability to support doctors in training.

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

Overall the practice provided good quality care to older patients. The practice ensured that its services are developed to meet the needs of older people and achieved this number of ways. The practice sent reminder letters to patients with long term conditions for their annual review. The practice provides medical services to two local nursing care homes. The premises and services had been adapted to meet the needs of the older and frail patients. Elderly and frail patients were seen in the ground floor consultation room, if required.

People with long term conditions

Good

Overall the practice provided good quality care to patients with long-term conditions. The practice had recall systems in place to ensure patients with long term conditions received appropriate monitoring and support. The practice was involved in regular cluster meetings for these patients and supported patients in their home. The practice held dedicated clinics for long terms conditions such as diabetes and asthma. Patients had a care plan in place to prevent unplanned admissions. The Patient Participation Group regularly organised education meetings, where variety of health topics for patient with long term conditions were discussed.

Families, children and young people

Good

Overall the practice provided good quality care to families, children and young patients. The practice had ongoing recall system for woman needing cervical cytology. The practice offered post-natal and child surveillance checks to all new mums and babies offering flexibility of appointments to suit their needs. The local midwifery team held a clinic at the practice every Tuesday to support all pregnant women. The practice has a dedicated reception staff who contacts parents to follow up on children who had missed their immunisations. The GPs had diverse areas of professional interest with general practice to support his patient group, which included paediatrics, family planning, women's health and breast screening.

Working age people (including those recently retired and students)

Good

Overall the practice provided good quality care to working age patients. The practice offers a wide range of appointments throughout the week between 8am to 6pm. Further to this there were extended hour appointments on Tuesday and Friday evening and Saturday mornings. We saw there was an automated check-in

Summary of findings

service in the practice, to ensure patients did not have to queue at the reception area. The practice is an accredited yellow fever centre, and offered a whole range of vaccinations and immunisations for travellers.

People whose circumstances may make them vulnerable

Good

Overall the practice provided good quality care to vulnerable patients. There were no barriers for patients in vulnerable circumstances. People wishing to register at the practice were always accepted. The practice maintained a learning disability register and saw these patients annually. The practice had comprehensive child and adult safeguarding policies procedures and staff were familiar with these. The practice discussed vulnerable patients regularly at clinical meetings, to ensure these patients' needs were met and to maintain awareness.

People experiencing poor mental health (including people with dementia)

Good

GPs referred patients to the local talking therapy service which offers both individual and group support. The practice offers private in house counselling service to patients, where the counsellor supports patient's with emotional and psychological problems. The practice had nominated GP mental health lead.

Summary of findings

What people who use the service say

We spoke with 10 patients which also included members of the patient participation group (PPG). A PPG is made up of a group of volunteer patients and practice staff who meet regularly to discuss the services on offer and how improvements can be made for the benefits. We received further feedback from 33 patients via comment cards. Majority of the feedback from patients was very positive. Patients were complimentary of all the staff and described them has friendly, respectful, caring and thoughtful. Patients were very happy with the service they received.

Patients told us the GP and nurses involved them with decisions about their treatment and care. Some patients told us they were provided with printed information when this was appropriate. Patients commented the practice was safe and always very clean. Patient feedback on appointment accessibility was generally positive. For example, some patients said they were able to get an appointment easily, and if they required an urgent appointment this was provided to them. Other patients commented the waiting time to see a GP of their choice was long and sometimes had to wait for over three weeks.

We were told that the GPs always explained procedures in great detail and were always available for follow up help and advice. Patients told us that they were aware the practice had offered a chaperone service but most of them told us they had not had the need to use it.

We reviewed patient feedback from the national GP survey from 2014 which had approximately 108 responses and the practice survey from 2014 which received 221 responses. The results from the national GP survey showed, 84% of patients said they were able to get an appointment when they last tried. Eighty seven per cent patients described their overall experience of the practice as good. Overall 79% of patients said they would recommend the practice to someone new to the area.

Areas for improvement

Action the service MUST take to improve

- Ensure all treatment rooms have appropriate facilities to ensure safe delivery of care. Carry out a risk assessment for one of the treatment rooms to ensure it is fit for purpose.

Magnolia House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead inspector, and a GP specialist advisor. The team included, a practice nurse and practice manager.

Background to Magnolia House

The practice was established in 1911 and moved to its current premises in 1963. The practice serves Sunningdale, Sunninghill, Windlesham and some areas of Ascot and Virginia Water.

The practice provides general medical services to over 9200 patients, with an older than average practice population and very low deprivation scores. Local demographic data indicates the practice serves a population which is one of the more affluent areas in England. Magnolia House practice has a high number of patients registered who are under 18 years of age and have a high proportion of over 65 year old registered with them.

The practice occupies a residential home and consultation and treatment rooms are spread on the ground and first floor. The practice had planned to move to an alternative site to ensure they had access to purpose built building, which met patient needs. This move had been supported by patients and staff; however, the planning permission had been recently refused.

Care and treatment is delivered by a number of GPs, Practice Nurses a Health carer and a Midwife. The practice also provides other private medical services in-house, such as counselling. Outside normal surgery hours patients were able to access emergency care from an Out of Hours (OOH) provider. Information on how to access medical care outside surgery hours was available on the practice leaflet, website and waiting area.

The practice has a General Medical Services (GMS) contract. GMS contracts are subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the British Medical Association.

The practice is a GP training practice. This was a comprehensive inspection.

The practice provides services from:

Magnolia House

Station Road

Sunningdale

Berkshire

SL5 0QJ

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Prior to the inspection, we reviewed wide range of intelligence we hold about the practice. Organisations such as local Healthwatch, NHS England, clinical commissioning group (CCG) provided us with any information they had. We carried out an announced visit on 22 October 2014. During our visit we spoke with practice staff team, which included GPs, practice nurses, health care assistant (HCA), and the administration team. We spoke with 10 patients including the Patient Participation Group (PPG) members who used the service and reviewed 33 completed patient comment cards. We observed interactions between patients and staff in the waiting and reception area and in the office where staff received incoming calls. We reviewed policies and procedures the practice had in place.

To get to the heart of patients experiences of care, we always ask the following five questions of every service and provider:

- 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
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

Requires improvement

Are services safe?

Our findings

Safe track record

The practice had systems in place to identify risks and improve quality in relation to patient safety. This was achieved through reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

We reviewed safety record and incident reports. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We reviewed records of significant events that occurred during 2014. We saw evidence to confirm staff had completed significant event analysis which included identifying any learning from the incident. Staff told us learning was shared with them and they were encouraged to discuss how the practice could improve services offered to patients.

We saw evidence as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. Significant events, incidents and complaints were investigated and reflected on by the GPs and the senior management team during regular clinical meetings. We saw examples where processes had been changed following incidents being reported. These included; introduction of baby clinics for immunisations where two nurses would be present to reduce the risks of error and to follow best practice.

The practice had not raised any safeguarding alerts within the last year. Systems were in place for reporting and responding to safety incidents and patient safety alerts. The practice used the computer system to process national patient safety alerts and there was evidence of an audit trail of alerts that had been reviewed. We saw some example of recent alerts. For example, we reviewed an alert in relation to insulin syringes and saw this had been appropriately dealt with.

Reliable safety systems and processes including safeguarding

The practice had comprehensive safeguarding policies and procedures in place to protect vulnerable patients. This provided staff with information, different types of abuse, how identify, report and deal with suspected abuse. A safeguarding lead had been appointed who had undertaken appropriate safeguarding training. The safeguarding lead attended safeguarding case conferences regularly and any changes and learning was communicated to the team through team meetings.

All staff we spoke with were aware of who the lead was and how they could access the policy on the practice computer system. Staff also had access to the contact details of child protection and adult safeguarding teams in the area. Staff we spoke with were able to discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We saw evidence all the GPs and nurses had received child safeguarding training up to level two and administrative and reception staff level one. We saw the adult and child safeguarding training for all staff was up to date.

We noted a safeguarding poster was displayed in the waiting area. This gave patients information about organisations they could contact for support, if they were suffering from abuse, or suspected abuse. This allowed patients to receive this information discreetly and opportunistically. The practice had protocols and guidance on how staff should deal with aggressive, abusive or violent patients

The practice had a chaperone policy in place. We saw notices in the waiting area and next to examination couches in the surgeries informing patients that they could request a chaperone. Some patients we spoke with told us they had been offered a chaperone if they required an intimate examination. We saw evidence in the last year 70 patients had used a chaperone.

We found no evidence which showed that those alerts which had not been seen were followed up.

Medicines management

The practice had management of medicines policies and procedures and staff knew how to access these. We found all medicines and vaccines stored were within expiry date

and there were appropriate stock levels. Vaccines were stored and transported safely. Vaccines were stored in fridges which monitored by the Health Care Assistant (HCA). We found the vaccine fridges were monitored every week day, except Tuesday. This was because the HCA did not work on that day. The nursing team informed us they will ensure one the nurses monitored this, going forward. No controlled drugs were kept on site. The practice had systems in place for safe disposal of medicines. Any medicines that needed destroying, patients were signposted to take this to the local pharmacy.

The practice had procedures for repeat prescriptions, and protocols for how to handle repeat prescription requests. Staff we spoke with knew how to access this information. We found the prescription pads were stored safely and securely. All prescriptions were signed by the GP before they were issued to the patient.

Evidence was seen of regular prescribing audits being carried out. The practice was responsive when new advice was received and carried out prescribing audits appropriately. We saw evidence that changes to medicine prescribing were made when required.

The practice had regular meetings with the local Clinical Commissioning Group (CCG) and discussed and reviewed their medicine management practises. The practice also submitted regular medicine management audits to the CCG.

Cleanliness and infection control

The practice had comprehensive infection control policy. This provided staff with information about aspects of infection control such as hand hygiene, personal protective equipment (PPE), waste management, safe use and disposal of sharps and how to deal with spillages. The policy did not include an inception and review date.

The practice nurse was the lead for infection control in the practice. The infection control lead had protected learning time complete three monthly infection control audits. We reviewed two infection control audits completed in the last six months. These showed the practice was scoring highly in all areas of infection control.

During our inspection we looked at all areas of the practice, including the GP surgeries, nurses' treatment rooms, patients' toilets and waiting areas. All appeared visibly clean, dust free and were uncluttered. The patients we spoke with commented the practice was clean and appeared hygienic. We observed in the ground floor patient toilet there was no notice on how children nappies should be disposed. We noted the foot peddled bin in this toilet was rusty. We saw in one of the consultation rooms non-disposable curtains were being used and these were being washed by the GP. There was no evidence to confirm what wash cycle had been advised and whether these were being cleaned in line with national guidelines. We saw evidence renewal schedule was in place for these curtains.

We found in one of the treatment rooms, which was used by the phlebotomist, there was no hand washing facility. Staff told us they would have to go into another room to wash their hands. We saw evidence lack of hand washing facility in this treatment room was identified in an infection control audit but did not find an action plan to address this concern. There was no risk assessment in place on the potential risks this treatment room placed on patients and how these risks were to be managed.

The practice had employed a cleaning company, who came in daily. We found there were no cleaning schedules for daily, weekly and monthly cleaning. This had not been documented or monitored. This meant the practice could not confirm if all areas had been thoroughly cleaned. We found appropriate arrangements were in place to enable the safe removal and disposal of any waste from the practice.

Equipment

Staff had access to a defibrillator and oxygen and the equipment was checked and recorded regularly to ensure it was in working order. Staff we spoke with knew the location of the resuscitation equipment. We saw evidence staff had received regular training in resuscitation, fire safety and health and safety. All new staff were made aware of the location of the fire extinguishers and fire exits during their induction programme.

Staffing and recruitment

Recruitment policies and procedures were in place. We reviewed the personnel files of eleven staff members, of staff that had been recruited in the last two years. We found all information required by the regulation was recorded in the individual staff files. This included an application or curriculum vitae for each staff member, references, records of any gaps in employment that were explored, a recent photo, identity checks and criminal records checks through

the Disclosure and Barring Service (DBS) were in place for appropriate staff. This ensured the practice had robust recruitment process in place and patients received service from suitably vetted staff.

We found a documented risk assessment was in place for staff the practice had deemed a DBS check was not needed and the low risk this posed to patients.

Monitoring safety and responding to risk

The practice had a comprehensive health and safety policies and procedures in place. This provided staff with information on specific responsibility for each staff member, in areas such as the building, maintenance and equipment, clinical waste and first aid. Staff we spoke with told us they how to access this information should the need arise.

The management team had systems in place to manage expected absences, such as annual leave, and unexpected absences, for example staff sickness. The reception staff for any unexpected leave within the team, they would cover each other. The reception team had a system of notifying the senior receptionist between 6:30-7am on that day, who the arranged cover from her colleagues. Staff told us this arrangement was worked very well and they had been able to arrange cover adequately. Annual leave for staff was managed to ensure there were sufficient reception staff on duty each day. The management team also managed the GP and practice nurse rota so there were enough GPs and nurses on duty to manage the telephone consultations, face to face consultations and home visits.

We found there was a control of substances hazardous to health (COSHH) assessment and risk assessment available for the storage of chemicals in the practice.

Information from data monitoring systems such as the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service, suggested the practice monitors the health and wellbeing of patients who experience poor mental health. This included regular medicine checks and physical health checks.

Arrangements to deal with emergencies and major incidents

The practice had effective systems and procedures were in place to deal with emergencies. The practice had a comprehensive 'Disaster Handling and Recovery' procedures in place to deal with emergencies that could interrupt the smooth running of the practice. This plan outlined protocols for staff to follow in the event of, losing main building, loss of telephone lines, loss of medical records and loss of computer system. The document was available to staff on the computer system. The practice manager also kept copies of the document and other insurance policies off site too. We saw records showing all staff had received training in basic life support. Staff had access to emergency medicines and we found these were within their expiry date.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing team we spoke with were able to describe and demonstrate how they access both guidelines from the National Institute for Health and Care Excellence and from local commissioners. New clinical guidance was shared during clinical team meetings and the implications for the practice's performance and patients were discussed. All the GPs we interviewed were aware of their professional responsibilities to maintain their knowledge.

Patients had their needs assessed and care planned in accordance to best practice. We reviewed records for patients with hypertension, which showed patients were on appropriate treatments and had regular reviews. We found all telephone consultations were documented and there was an audit trail of the advice given.

We found the practice refers patients appropriately to secondary and other community care services. Referrals were made using the Choose and Book service. We saw some examples of referrals that the practice had recently made. This included cardiology, neurology, endoscopy and dermatology referrals. We found the referrals were dealt with appropriately and in timely manner. We saw evidence of appropriate use of Two Week Wait referrals. We saw minutes from team meetings where referrals were discussed and any improvement to practise were discussed and shared with all the GPs and nurses. Any staff we who were unable to attend, were sent this information by email.

Management, monitoring and improving outcomes for people

The practice routinely collects information about patients care and outcomes. The practice used the Quality and Outcomes Framework (QOF) which is a voluntary system for the performance management and payment of GPs in the National Health Service. This enables GP practices to monitor their performance across a range of indicators including how they manage medical conditions. The last QOF data available to CQC showed the practice performs well in comparison to other local practices. The practice achieved well on some specific areas including dementia, epilepsy and palliative care.

The practice showed us various clinical audits that had been undertaken in the last four years. These included audits for prescribing, minor surgery, coils and implants, inadequate smears, and intrauterine contraceptive device (IUCD). We saw examples of completed audits where the practice was able to demonstrate the changes resulting since the initial audit and these were recorded. For example, the inadequate cervical smears repeat audit dated March 2014, was carried out to determine the percentage rate of inadequate smears for individual GPs or nurses over a two year period. The audit showed all GPs and nurses were found to have had an inadequate rate of fewer than 2%. This meant that there was no need for the staff to undergo retraining. We saw evidence results of audits were discussed during clinical meetings and recommendations and learning was shared with staff. We found the nursing team did not complete individual clinical audits. The practice also carried non-clinical audits. These included audits on access, appointments and urgent requests on duty days.

Effective staffing

All GPs had undertaken regular annual appraisals and either been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).The nursing team had been appraised annually. We saw learning needs had been identified and documented action plans were in place to address these. Staff told us the practice was proactive and supportive in providing training that been identified.

The practice had systems in place to monitor staff training. The practice manager recorded all training staff had received on a training matrix and used this to monitor staff training. This document showed staff had received training in adult and children safeguarding, confidentiality, fire training, infection control, resuscitation and customer service. The practice had developed a customer service training manual, and had shared this with local practices.

The practice had some changes in management in the last two years. Senior management told us the practice had found the recruitment process difficult. A new GP partner had been recruited and were due commence their position soon. Staff we spoke with told us the practice had managed the changes well and the staffing team was currently

Good

Are services effective?

(for example, treatment is effective)

stable. The practice used locum GPs when there was shortage of staff. The practice only used locums that had worked with the practice regularly or were supported by previous trainees and did not use agency locums. This ensured continuity of care was maintained. Staffing levels were frequently reviewed by the practice manager, to ensure they had enough staff members with appropriate skills.

Working with colleagues and other services

The practice demonstrated a multi-disciplinary approach to care and treatment, which had benefited patients. The practice worked with district nurses, health visitors and palliative nurses. The midwifery team held regularly clinics at the practice premises and attended weekly clinical meetings. The practice held regular multi-disciplinary meetings which were attended by district nurses, midwives, local authority and GPs and nurses from local practices. We reviewed minutes of a recent palliative care meeting, dated 19 September 2014 and we saw there was discussion on all patients receiving palliative care and how they could be best supported. Also treatment plans for patients who had been newly diagnosed with cancer were discussed and action plan for all these patients to receive their cancer care reviews were put in place.

Blood results, X-ray results, letters from hospital accident and emergency and outpatients and discharge summaries, and the 111 service were received electronically and by post. Blood results, X ray, letters from hospital A&E reports, and reports from out of hours services were seen and actioned by a GP, in a timely manner.

Information sharing

The practice worked closely with district nurses and the midwifery team and the practice had systems in place to share patient information securely and quickly to them. We noted important patient information was shared during palliative care and clinical meetings. For example, we saw minutes of meeting dated March 2014; showed GPs and nursing staff shared information in areas such as, recent referrals, medicine, complaints and deaths of patients registered with the practice.

Consent to care and treatment

The GPs we spoke with had a sound knowledge of the Mental Capacity Act 2005 (MCA) and its relevance to general practice. They were able to describe what steps to take if a patient was deemed to lack capacity. The practice had MCA 2005 protocols in place and the GPs and nursing staff had access to these. The GPs we spoke with told us if a patient was deemed to lack capacity then best interest meetings were held and documented in patient records. The nursing team we spoke with understood the importance of consent; however they were not aware of the MCA 2005. They told us they had not received any training for this. We saw evidence written consent for minor surgery procedures was sought.

The GPs and nursing staff had a sound knowledge of the Gillick competency considerations, when dealing with young patients. Gillick competence is used to decide whether a person (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental consent or knowledge.

Health promotion and prevention

The practice offers all new patients registering with the practice a health assessment with the practice nurse. An appointment with GP is offered if complications are detected or if the patient is on drug treatment.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Pneumococcal vaccine was given to patients who are over 65 years of age, in line with national guidance for older people. Last year's performance for flu immunisations was above average for the CCG.

There was health promotion material available in the waiting area. This included information on dementia service, dealing with loneliness, and support for patients with learning disability, flu immunisations and carer's information. The PPG organised health education meetings to promote health information and self-care.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. Patients we spoke with told us they were treated with privacy, dignity and compassion. We observed conversations could not be overheard from outside the consultation rooms. The nursing team we spoke with told us, they did not interrupt a GP consultation to ensure patient privacy and dignity was maintained.

During our observation in the waiting and reception area we found patient confidentiality could be compromised due to limited space in the reception area. There was a potential for patients in the queue could overhear telephone conversations due to space restriction. The reception team informed us they tried not to reveal names and sensitive information and did have access to a spare room should patients wish to discuss in privacy. However, we found there was no information in reception area to inform patients of this provision, should a need arise. We noted there was a notice in the reception area requesting patients to give other patients space to discuss their medical needs with the reception staff, however this may be difficult to maintain during periods.

A confidentiality policy was in place and staff we spoke with were familiar with these. Staff told us they had received training in patient confidentiality and this was supported by the training document made available to us. During the inspection we observed staff members were careful to follow the practice's confidentiality policy when discussing patient's treatments in order that confidential information was kept private. Staff told us all computers were password protected and only the practice staff had access to the systems.

We reviewed the recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 221 patients undertaken by the practice's Patient Participation Group. The responses generally were positive and patients were satisfied with the service provided by the practice. For example, the 2014 patient survey received approximately 108 patient responses. We found, 87% of patients rated their overall experience with the practice as good and 87% of patients said the last GP they saw or spoke with was good at treating them with care and concern. Ninety four per cent patients said they had confidence and trust in the GP they saw and 82% of patients said the receptionists at the practice were helpful. Seventy per cent patients were satisfied with the level of privacy when speaking to reception staff at the practice.

Patients completed CQC comment cards to provide us with feedback on the practice. We received 33 completed cards and generally the feedback was positive. Patients said staff were helpful, caring, and respectful. Some patients commented the reception is always busy, but have found the staff to be always friendly and helpful. Patients described the service as excellent and very good.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the 2014 national patient survey showed, 91% of patients said the GP they saw was good at listening to them. Seventy two per cent of patients said the GP they saw was good at involving them in decision about their care and 76% of patients commented the nurse they saw or spoke with was good at explaining tests and treatments. Ninety one per cent of patients said the GP they saw was good at giving them enough time.

Patients we spoke with told us they were sufficiently involved in decisions about their care and treatment they received. They also told us they felt listened to and supported by staff. Patient feedback on the comment cards we received was also positive and aligned with these views.

The practice had access to translation services for patients who did not speak English as a first language. Staff told us this service was rarely used and this was supported by the patients we spoke with.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the

Good

Are services caring?

practice and rated it well in this area. The patients we spoke with on the day of our visit told us staff were compassionate and helpful, and provided support to them when required.

Notices in the patient waiting room, on the TV screen and patient website also signposted people to a number of support groups and organisations, such as carer support, child counselling, dealing with loneliness for older people, memory loss and bereavement support. The practice website had information about self-care and minor illness.

The practice Patient Participation Group (PPG) organised regular health meetings, where various health topics were discussed. For example, the meeting held on 16 October covered micro-incisions cataract minor surgery and latest retinal treatment. These sessions were led by a Hospital Consultant in the relevant health topic and were organised by the PPG. We saw the upcoming meetings were planned for topics such as strokes and treatment, arteritis and asthma. PPG members told us these meetings were popular and regularly attended by Magnolia House patients and those from other local practices. The PPG also sent out regular newsletters to share information about relevant health topics and what was happening in the practice.

The GPs and nurses we spoke with told us patients who had suffered bereavement were offered an appointment and were signposted to local support groups, counselling and provided with advice hand-outs. One staff member we spoke with told us they had suffered bereavement recently, and felt supported by the practice during the difficult time.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was responsive to patients needs and had sustainable systems in place to maintain the level of service provided. The practice used the risk stratification tool, which enabled them to profile patients by allocating a risk score dependent on the complexity of their disease type. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes, care plans for patients with palliative care needs and reviews for patients with long term conditions. The practice held regular meetings with the local CCG, to discuss patient needs and how they were going deliver services to these patients.

Patients benefited from a stable staff team because staff retention was high, which enabled good continuity of care and accessibility to appointments with a GP of choice. All patients needing to be seen urgently were offered same-day appointments and there was an effective triage system in place. Patients were reminded about their appointment via text service, and patients were also able to cancel by text.

This included; all patients who were 75 years of age and over had a named GP. The practice ran flu, shingles and pneumonia vaccine clinics. The practice had systems in place to communicate information about these clinics for elderly patients, which included by letter and text. The practice also ran flu clinics at some local residential homes. Home visits were arranged for frail and elderly patients

The practice had trained nurses who could deal with minor illnesses including coughs, colds and rashes to ensure the practice was responsive to all health needs. In addition the nursing were available every day to help with health checks, dressings, travel advice and blood tests. The practice offered options to book appointments online, and make requests for repeat medicines online which was particularly useful for patients with work commitments who unable to contact the practice during opening times.

A range of clinics and services were offered to patients, which included family planning, antenatal, children's immunisation and minor illness. The practice ran regular nurse specialist clinics for long-term conditions. These included asthma, diabetes and cardiovascular diseases.

Longer appointments were available for patients if required, such as those with long term conditions. GPs placed all new patients who were diagnosed with long term condition on practice register and organised recall programmes accordingly.

The practice caters for two large nursing care homes. A designated GP visited the care homes on a weekly basis, and further visits were carried as necessary. The practice also provides private medical services to local schools. The GP held two clinics on a weekly basis. These patients were also registered as NHS patients, and were fitted in if they were needed to be seen urgently on a non-school visit day.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss patients, their families care and support needs. The practice had low number of patients with a learning disability. These patients were regularly monitored by their named GP and annual physical health checks were offered appropriately. The practice worked collaboratively with other agencies, regularly updated shared information to ensure good, timely communication of changes in care and treatment.

District nurses and end of life care nurses attended the monthly clinical meetings where individual patients could be discussed if appropriate. In addition district nurses and midwives were based in the same building and called into the practice when information needed to be shared.

The practice had systems in place with secondary care providers to ensure information was available when a referral was made or when results where available. Any action requested by the hospital or Out of Hours (OOH) service was communicated to the practice.

We spoke with three members of the patient participation group (PPG). They gave us examples of improvements that had been made following discussions between the PPG and the practice. This included an emergency care protocol for patients to inform them of the services available at the practice and by the local secondary care providers. Patients had commented about this during recent patient survey, and had asked for further information on repeat prescriptions and appointment system. We saw this information was available in the waiting area and practice website.

We found generally the equipment and facilities used by the practice were appropriate. We saw one treatment room

Good

Are services responsive to people's needs?

(for example, to feedback?)

was limited in space and access and this could be a potential risk to patients. The room only had a chair for patients. If a patient was to collapse or felt unwell during treatment, staff recognised it would be difficult to treat them.

Tackling inequity and promoting equality

The practice understood the needs of the practice population and had systems in place to meet their needs. During our visit we observed GP and nursing staff collecting frail patients from the waiting area and providing them with relevant support. The practice did not have lift system in place and we noted most of the consulting rooms where on the first floor. However patients with limited mobility were seen on the ground floor. The practice had reserved car spaces for patients with disabilities. The practice had ramp access at the front door of the building. Adapted toilet and washroom facilities were available for patients with disabilities.

The practice had access to a telephone translation service when a patient did not speak English as a first language. Some staff had received Equality and Diversity training in the last 12 months.

The practice had low number of patients in the vulnerable groups, such as patients with learning disability, homeless patients and travellers. The GP and nursing staff discussed vulnerable patients regularly during clinical meetings, to maintain awareness.

Access to the service

The practice offered a range of appointments to patients every weekday between the hours of 8am and 6pm. The practice opened for extended hours appointments on a Tuesday and Friday evenings and offered early morning appointments between 7am to 8am. The practice was also opened on Saturday mornings, where pre-bookable appointments could be made. This benefitted patients who worked full time.

The practice website and leaflet outlined how patients could book appointments. Patients were able to book appointments in person, by telephone or online. Appointments were available in a variety of formats including pre-bookable appointments, a telephone triage system, on the day and emergency appointments and daily 'duty' doctor system. These ensured patients were able to access healthcare when they needed to.

Patients were able to organise repeat prescriptions online. The practice turned around repeat prescriptions within 48 hours. The practice had trained the local nursing home staff to use the EMIS online prescription system to enable care home staff to request the service user's prescription. The practice found this had a very positive impact on their workload and efficiency.

Patients we spoke with were generally happy with the appointment system. Patients told us they could see a GP or nurse on the same day if they needed to. Patients said to see a GP of their choice they had to wait and that appointments were often overrun, but otherwise they were satisfied with the appointment system. Patients were asked if they were willing to see any GP how soon were they able get an appointment, in the PPG 2013 survey. Twenty seven per cent of patients said next working day, 31% of patients said within two working days, 14% of patients said within four working days and 14% of patients said within one week.

The GP national survey 2014 showed 84% of patients were able to get an appointment to see or speak to someone the last time they tried and 98% of patients said the appointment they got was convenient. Sixty nine per cent of patients described their experience of making an appointment as good and 50% were seen by their preferred GP. Fifty seven per cent patients felt they don't normally have to wait too long to be seen.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out of hour's service. If patients called the practice when it closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out of service was provided through the practice leaflet and website.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy and procedures were in line with recognised guidance. The practice did not have a designated person responsible who handled all complaints in the practice. All the complaints were addressed to the practice manager or one of the GPs. The practice kept a record of all written complaints received.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The complaints we reviewed had been investigated by the practice manager and responded to, where possible, to the patient's satisfaction. We found no evidence that the practices recorded verbal complaints.

The practice had systems in place to review complaints received by the practice and ensured they learnt from them. The practice reviewed all incoming complaints in the next clinical meetings. The minutes of these meetings demonstrated a discussion of the complaints and the relevant learning points. For example, a patient had complaint more appointments with nurses were needed, for children immunisations and that these should be offered outside school hours. The practice made the decision to increase nursing staff.

We found patients' comments made on the NHS Choices website were monitored. We saw some complaints had been responded to with apology provided where necessary and others were not answered.

The patients we spoke with told us they would be comfortable making a complaint if required. They said they were confident a complaint would be fairly dealt with and changes to practice would be made if this was appropriate.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Clinical leadership and the integration of the practice's patient participation group (PPG) reflected this. We found details of the vision and practice strategic plans were part of the practice key organisational objectives. These included objectives such as, providing exemplary evidence based healthcare to all patients, to encourage and monitor progress of GP registrar and all learners and to maintain review and update of necessary working practices. The staff we spoke with were aware of the vision and values of the practice and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the practice computer system. These included policies in children and adult safeguarding, infection control, confidentiality and health and safety. We noted the infection control policy did not include implementation and review date.

The practice had systems in place to monitor all aspects of the service such as complaints, incidents, safeguarding, risk management, clinical audits and infection control. All the staff we spoke with were aware of each other's responsibilities. All the policies we looked at had been reviewed and were up to date. The systems and feedback from staff showed us that strong governance structures were in place.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed they were performing in line with national standards. We saw evidence QOF data was regularly reviewed and discussed in team meetings and actions plans were implemented to improve outcomes. We saw practice performed well in areas such as dementia, obesity and asthma.

The practice had regular clinical meeting. We reviewed minutes of four recent clinical meetings. The meetings followed a regular agenda and significant events, enhance services, medicine, referrals, complaints and staff training were always discussed. The practice regularly submitted governance and performance data to the Clinical Commissioning Group (CCG).

Leadership, openness and transparency

Staff told us they felt there was an open culture at the practice and they felt valued and well supported. The practice had a clear leadership structure which had named members of staff in lead roles. These included lead roles in clinical areas such as minor surgery, dermatology and cardiology. Other lead roles included, a safeguarding lead for the practice, one of the GP partners was responsible for training and development and another GP partner for recruitment and human resources. Staff we spoke with were clear about their own roles and responsibilities. Staff told us they were support by a strong and passionate management team. Staff we spoke with knew how and who to approach for advice if a concern arose.

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

The practice had an active patient participation group (PPG), where 11 members attended. There was also a virtual PPG of approximately 314 members who the PPG made contact with regularly to involve in decisions about the running of the practice. The PPG advertised information on how to join the group on the practice website, handed out leaflets, spoke to patients personally and broadcasted information on the information screen in waiting area. The clinician also informed patients about the PPG, during consultation, during visits to the nursing homes and whilst on home visits for housebound population. The practice manager invited all known disabled patients to the join the group. The current virtual PPG was represented by elderly, housebound and patients from the local nursing care home.

The PPG was also responsible for creating the practice survey and analysing the results. The PPG members told us that the survey action plan from 2014 was created by the PPG. We spoke with four PPG members. They told us they met every two months and meetings were attended by a GP and the practice manager. Members of the PPG told us they felt valued and thought their views were listened to.

Are services well-led?

Good

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

We were given examples of where the PPG had highlighted areas where PPG feedback was acted on and changes were made. For example, the entrance to the practice had been adjusted to ensure easier access for all patients.

Staff told us they felt involved in the running of the practice. They told us they were encouraged to share ideas for best practice and their suggestions have been acted upon. This included, introduction of new desks in the administration team office and additional computer for staff to use on an ad hoc basis was also purchased.

The practice had a whistle blowing policy. The policy included information about the external organisations staff could report their concerns to however, the policy did not have information about who staff could contact if they had concerns about the practice.

Management lead through learning and improvement

Mandatory training was provided during the weekly staff meetings. These meetings were also an opportunity for other training to be delivered during protected learning time, and we saw training was monitored and arranged when required.

All staff had regular training and development opportunities. Staff had received regular appraisal to discuss individual support needed to develop their knowledge and skills. The nursing team told us they used to have formal supervision, however this had lapsed for some time lately and it was difficult to hold these due time constraints. Staff we spoke with told us the practice encouraged staff to seek further training to ensure they were able to perform their jobs appropriately. Clinical staff had access to new legislation and changes through team meetings. The non-clinical team also had regular team meetings, where learning was shared and new guidance and protocols were discussed.

We found systems were in place for staff to access to learning and improvement opportunities.

The practice was a GP training practice and completed self-assessments to confirm their ongoing suitability to support doctors in training.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control **The registered person must ensure an effective operation of systems is in place, designed to assess the risk of and prevent, detect and control the spread of a health care associated infection. Regulation 12 (2) (a), (b).**