Manor House Surgery - Bridlington

Quality Report

Providence Place
Bridlington
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Website: http://www.manorhousesurgery.com/Home

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

Ratings

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

Summary of findings

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Letter from the Chief Inspector of General Practice

This practice is rated as Good overall. (Previous inspection June 2015 – Good)

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? - Good

As part of our inspection process, we also look at the quality of care for specific population groups. The population groups are rated as:

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

Working age people (including those recently retired and students – Good

People whose circumstances may make them vulnerable – Good

People experiencing poor mental health (including people with dementia) - Good

We carried out an announced comprehensive inspection at Manor House Surgery on 28 February 2018 as part of our inspection programme.

At this inspection we found:

- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

We saw two areas of outstanding practice:

- The senior practice nurse had supported a patient with learning disabilities to access support regarding hair styles and make up to support their lifestyle choices. They had also referred to them to a specialist health professional. We saw evidence from three local care homes thanking the practice for the care and support they provided for patients with learning disabilities. This included home visits and dedicated clinics so patients were seen promptly.

Summary of findings

- Changes to the in house diabetes service had resulted in an increase in identifying patients with pre-diabetes and improved control for patients already diagnosed. The practice had identified 1127 patients with pre-diabetes. All the HbA1c diabetes blood test results were reviewed by the lead nurse before they were filed. This meant that if patients had deteriorating diabetes control or if had improved it was being picked up much quicker and enabling staff to make plans to adjust treatment and/or plan the next follow-up in response. The diabetes consultant from the local hospital had visited the practice in February 2018. They reviewed the process and felt it was something that could be shared with other practice teams as not only did it seem to improve patients' diabetic control but was also more efficient.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Summary of findings

Outstanding practice

We saw two areas of outstanding practice:

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Manor House Surgery - Bridlington

Detailed findings

Our inspection team

Our inspection team was led by:

a CQC lead inspector**.** The team included second CQC Inspector and a GP specialist adviser (the GP advisor was not on site but spoke to the GPs and practice pharmacist by telephone during the inspection).

Background to Manor House Surgery - Bridlington

Manor House Surgery, Providence Place, Bridlington Humberside YO15 2QW is located in a converted Georgian property in Bridlington. Parking is available at the practice and there are accessible facilities. Consulting and treatment rooms are all on the ground floor. The practice provides services under a General Medical Services (GMS) contract with the NHS North Yorkshire and Humber Area Team to the practice population of 8461, covering patients of all ages. There is a branch site at Flamborough, The Surgery, Chapel Street, Flamborough YO15 1LQ. The Manor House and Flamborough surgeries were visited during the inspection. The practice website can be found by following the link http://www.manorhousesurgery.com/Home

The provider is registered to the provide the regulated activities Diagnostic and screening procedures, Family planning, Maternity and midwifery services, Surgical procedures and Treatment of disease, disorder or injury.

The proportion of the practice population aged 65 and over age group is higher than the local CCG and England average. The proportion of the practice population in the under 18 years age group is lower than the local CCG and England average. The practice scored three on the deprivation measurement scale, the deprivation scale goes from one to ten, with one being the most deprived. People living in more deprived areas tend to have greater need for health services.

The practice has six GP Partners, four male and two female, three work full time and three work part time. There is a full time GP registrar (a Dr who is training to become a GP). There is one full time male advanced nurse practitioner (ANP) and a part time clinical pharmacist. There are four practice nurses, all female, one works full time and three work part time. There are two health care assistants and a phlebotomist, all female and all work part time. There is a practice manager, an assistant practice manager and a team of administration, reception and secretarial staff.

The Manor House Surgery is open between 8am to 6pm Monday to Friday. Appointments with the GPs and ANP are available from 8.30am to 10.40am and 2pm to 5.30pm Monday to Friday. The Monday morning 'Turbo' clinic operates with no pre-bookable appointments, patients who need to be seen urgently ring and are given an urgent appointment. The Flamborough site is open from 2pm Tuesday to Friday. There are a small number of GP pre-bookable appointments available and a sit and wait service. A health care assistant attends Flamborough every Tuesday and Friday at 1.30pm for all routine care including bloods, health checks and some injections.

The practice, along with all other practices in the East Riding of Yorkshire CCG area have a contractual agreement for the Out of Hours provider to provide OOHs services from 6.00pm on weeknights. This has been agreed with the NHS England area team.

Detailed findings

When the practice is closed patients use the NHS 111 service to contact the OOHs provider. Information for patients requiring urgent medical attention out of hours is available in the waiting area and on the practice website.

Good

Are services safe?

Our findings

We rated the practice, and all of the population groups, as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep patients safe and safeguarded from abuse.

- The practice had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an on-going basis. Disclosure and Barring Service (DBS) checks were undertaken where required. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- There was an effective system to manage infection prevention and control.
- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. The advanced nurse practitioner had provided sepsis awareness training to the reception staff.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- Individual care records were written and managed in a way that kept patients safe. The care records we saw showed that information needed to deliver safe care and treatment was available to relevant staff in an accessible way.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment. There was a documented approach to the management of test results and for the processing of letters and documents received from hospitals.
- Referral letters included all of the necessary information.

Good

Are services safe?

Safe and appropriate use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. However the practice needed to review the storage and signage of oxygen cylinders at the Manor House surgery. The practice informed us after the inspection that they had obtained signs for the oxygen and had re-located the oxygen cylinders so they were not under the staircase. Also we found emergency medicines were not locked in a cupboard when the branch surgery was closed. Following the inspection the practice informed us that all medicines were now stored in a locked cupboard when the practice was closed.
- The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.
- The percentage of antibiotic items prescribed by the practice that were Co-Amoxiclav, Cephalosporins or Quinolones was 2%. This was positive and below the local CCG percentage of 6% and England average of 9%.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example; following an incident the storage arrangements for travel vaccines and other vaccinations was reviewed and travel vaccines were now stored in a separate refrigerator.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts.

Good

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice and all of the population groups as good for providing effective services.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and on-going needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff used appropriate tools to assess the level of pain in patients. Staff worked with the local pain clinic to look at managing pain without the use of medication.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- Older patients who were frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs.

People with long-term conditions:

- Patients with long-term conditions (LTC) had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Changes to the in house diabetes service had resulted in an increase in identifying patients with pre-diabetes and improved control for patients already diagnosed. The practice had identified 1127 patients with pre-diabetes. All the HbA1c diabetes blood test results were reviewed by the lead nurse before they were filed. This meant that if patients had deteriorating diabetes control or if it had improved it was being picked up much quicker and enabling staff to make plans to adjust treatment and/or plan the next follow-up in response.
- Same day appointments were available with nurses for patients who had an exacerbation of their LTC, for example respiratory disease.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for children up to aged two for the vaccines given were in line with the target percentage of 90% or above.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.

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

- The practice's uptake for cervical screening was 76%, which was slightly below the 80% coverage target for the national screening programme. The practice sent reminder letters to patients who did not attend for screening and telephoned them if necessary.

Good

Are services effective?

(for example, treatment is effective)

- The practices' uptake for breast and bowel cancer screening was in line the national average.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- There was a lead GP and nurse for patients with learning disabilities and the practice held dedicated clinics for these patients.
- The practice used 'The Smear Test Film' to encourage uptake for patients with learning disabilities.
- Annual face to face health checks were carried out either in the surgery or at the patient's residence. This included undertaking blood tests and breast examinations. We saw letters from staff at three care homes saying how valuable the health checks were and how understanding and supportive the staff were. This included how helpful checks being done in the patients residence was for some of the patients. In some cases the health checks had identified problems which had then had further investigation and treatment.

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

- 93% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was above the local CCG average of 85% and national average of 84%.
- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The number of registered patients the practice had identified with dementia had increased over the past three years from 91 to 138.
- 92% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the local CCG average of 93% and national average of 90%.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example 93% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This was comparable to the local CCG average of 92% and national average of 91%.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example the practice had completed audits to check if patients taking a medicine for a heart condition were being monitored in line with current guidelines. An audit was done in November 2016 which showed that patients were not being monitored correctly. The audit was repeated in November 2017 and showed that 100% of patients were having the required monitoring. The audits demonstrated that areas identified for improvement had been addressed and on-going monitoring implemented to monitor the changes introduced were effective and sustained.

Where appropriate, clinicians took part in local and national improvement initiatives. For example; one of the GPs was the lead working with the CCG and other practices in the area to look at the increasing levels of prescribed opiate addiction. They had also worked with the local cancer lead to look at their two week wait cancer referrals.

The most recent published Quality and Outcomes Framework (QOF) results for 2016/2017 showed the practice achieved 100% of the total number of points available compared to the local CCG average of 97% and national average of 96%. (QOF is a system intended to improve the quality of general practice and reward good practice). The practice had 9% exception reporting, this was comparable to the local CCG and national average of 10%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to carry out their roles. For example, staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.

- The practice provided staff with on-going support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical and peer supervision and support for revalidation. The induction process for healthcare assistants included the requirements of the Care Certificate. The practice ensured the competence of staff employed in advanced roles by review of their prescribing and regular discussion of clinical decision making. The advance nurse practitioner (ANP) had weekly protected time for meetings with their clinical lead or clinical supervisor. These meetings included discussions of clinical cases and a sample of supervisor-selected case reviews for review of clinical decision making. An informal audit was carried out in 2017 where all referrals made by the ANP were monitored during a 6 month period; no specific learning needs were identified.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. Staff had completed mandatory training such as fire safety and infection control.
- We received positive feedback from staff about the support, opportunities and time they were given to train and develop. For example; the advanced nurse practitioner had completed prescribing and minor ailments courses.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity and flu vaccinations.
- The practice had referred 70 patients to the 'Exercise on Prescription' scheme, 33 patients had completed the course and 20 were still attending. Results included patients losing weight, increasing their activity levels and their blood pressure being lower.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.

Good

Are services effective?

(for example, treatment is effective)

- The practice monitored the process for seeking consent appropriately.

Good

Are services caring?

Our findings

We rated the practice, and all of the population groups, as good for caring.

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 23 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with the results of other feedback received by the practice.

For the National GP patient survey published in July 2017, 223 survey forms were distributed for the practice and 128 forms were returned, a response rate of 57%. This represented about 1% of the practice population. Results from the survey showed patients felt they were treated with compassion, dignity and respect. The practice results were comparable to the local CCG and national averages for satisfaction scores on consultations with GPs and nurses. For example:

- 92% said the last GP they saw was good at listening to them: local CCG average was 91% and national average 89%.
- 98% said they had confidence and trust in the last GP they saw or spoke to: local CCG average was 97% and national average 95%.
- 91% said the last GP they saw or spoke to was good at treating them with care and concern: local CCG average was 89% and national average 85%.
- 93% said the last nurse they saw or spoke to was good at listening to them: local CCG average was 94% and national average 91%.
- 95% said the last nurse they saw or spoke to was good at treating them with care and concern: local CCG average was 93% and national average 91%.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care and were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given). Information on the Accessible Information Standard was available on the practice website:

- Interpretation services were available for patients who did not have English as a first language. The practice website had the facility to translate information into other languages. 99% of the practice population were of white ethnicity.
- Patients were also told about multi-lingual staff who might be able to support them. Two of the GPs spoke other languages.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. Carer identification forms were displayed in the waiting area and the new patient questionnaire asked patients if they were a carer. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 238 patients as carers (3% of the practice list).The number of carers on the register had increased by 47 in the previous 12 months.

- The practice operated a personalised list system so staff were aware of the needs of patients and their carers. This enabled them to offer support when required and advice on how to access services. Staff were aware of the carer support available via the local council and referred patients for carers' assessments, with their consent.
- Carers were offered health checks with the practice nurse and flu vaccinations. In the past year 33 carers had

been identified when the person they were supporting had been having a dementia care plan review. They had all been invited for a health check and 19 of the 33 had attended.

- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.
- Information on local and national bereavement support was available in the waiting area.

Results from the national GP patient survey published in July 2017 showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were comparable with local CCG and national averages:

- 91% said the last GP they saw or spoke to was good at explaining tests and treatments: local CCG average was 89% and national average 86%.
- 88% said the last GP they saw or spoke to was good at involving them in decisions about their care: local CCG average was 85% and national average 82%.
- 89% said the last nurse they saw or spoke to was good at explaining tests and treatments: local CCG average was 92% and national average 90%.
- 86% said the last nurse they saw or spoke to was good at involving them in decisions about their care: local CCG average was 86% and national average 85%.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.
- Conversations with receptionists could be overheard by patients in the waiting room; however no personal or confidential information was discussed.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

We rated the practice, and all of the population groups, as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs. For example telephone consultations, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, a hearing loop was available for patients with hearing impairments and we observed staff calling patients for their appointments and assisting patients who needed help opening doors.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients. They offered urgent appointments and home visits by the GPs and practice nurses for those with enhanced needs and when there was an urgent clinical need and patients were unable to attend the practice.
- The practice had worked in partnership with other local practices, the CCG, public health and the voluntary sector to better understand and provide for the needs of the elderly. They participated in the Easy Care Project which helped identify patients social needs.
- Since summer 2017 a community link worker from the East Riding Voluntary Action Service had been integrated into the practice team and visited the practice twice a week. They supported the older patients with social prescribing which helped maintain their independence and combat loneliness.
- The percentage of the practice population over 65 was 35% compared to the local CCG average of 25% and England average of 17%. One of the GPs had become registered as a GP with a special interest in Elderly Medicine and provided expertise within the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs. The practice also did structured annual reviews for patients with coeliac disease, a LTC that was not included in the Quality and Outcomes Framework.
- A wellbeing interview was completed and personal care plans were developed. For example, patients with respiratory disease having access to rescue medication for exacerbations. This included clear written plans and instructions for emergency advice and follow up.
- There were daily emergency LTC exacerbation appointment slots available with the nursing team.
- The practice had employed a clinical pharmacist who supported the LTC clinics with comprehensive medication reviews and also undertook medication reconciliation and patient contacts after hospital discharge.
- The practice communicated regularly with the local district nursing team, community physiotherapists and occupational therapists, stroke team, heart failure nurses, pulmonary rehabilitation team and the falls service to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- All parents or guardians calling with concerns about a child or small infant were offered a same day appointment when necessary.
- Joint appointments were offered for the six week post natal check with the GP for mothers and babies six week check with the health visitor.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, online appointment booking and prescription ordering.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.
- Volunteers from the practice patient participation group had promoted men's health awareness week in June 2017.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability.
- The practice used easy read materials and longer appointments were available which helped to empower the patients and their carers.
- The senior practice nurse had supported a patient with learning disabilities to access support regarding their lifestyle choices. They had also referred to them to a specialist health professional.
- We saw evidence from three local care homes thanking the practice for the care and support they provided for patients with learning disabilities. This included home visits, seeing patients promptly when they came to the surgery so they didn't become distressed and treating patients with dignity, respect and compassion.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. We saw an example of how the practice managed an elderly patient with dementia and how concerns regarding their safety were highlighted and reflected on in the practice meetings.
- There was continuity of care with named GPs.
- The practice worked closely with the local mental health teams and supported patients to access service including psychological therapies and online cognitive behaviour therapy.
- The practice was a mental health teaching practice for third year medical students and worked closely with the Hull and Yorkshire Medical School.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- We received 23 patient Care Quality Commission comment cards during the inspection, six patients commented it could sometimes be difficult to get an appointment.

For the National GP patient survey published in July 2017, 223 survey forms were distributed for the practice and 128 forms were returned, a response rate of 57%. This represented about 1% of the practice population. Results from the patient survey showed that patients' satisfaction with how they could access care and treatment was more than 10% below the local CCG and national averages. For example:

- 69% of patients who responded were satisfied with the practice's opening hours: local CCG average was 80% and national average 80%.
- 45% of patients who responded said generally they could get through easily to the practice by phone: local CCG average was 68% and national average 71%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 66% of patients who responded said they were able to get an appointment to see or speak to someone the last time they tried: local CCG average was 77% and national average 75%.
- 58% of patients who responded described their experience of making an appointment as good: local CCG average was 74% and national average was 73%.

The practice had reviewed its' appointment system and introduced changes at the beginning of 2018. These included increased same day access, more telephone consultations and more medication reviews by telephone. The practice was also planning to renew its telephone system.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. Nine complaints were received in the last year. We reviewed three complaints and found that they were satisfactorily handled in a timely way. However lessons learned were not always clearly recorded.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted on findings to improve the quality of care. For example; after a GP visit was carried out in a care home it was not clear what treatment the patient required. A letter was sent to the care home clarifying treatment needed.

Are services well-led?

Good

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

Our findings

We rated the practice and all of the population groups as good for providing a well-led service.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.
- The practice monitored progress against delivery of the strategy.
- The practice recognised that it was a challenge to recruit staff to the Bridlington practices and had worked to become a training practice so they could 'grow their own' staff. The practice was the only training and teaching practice for GP Registrars and medical students in Bridlington. This was the first GP specialist registrar training to take place in Bridlington in over a decade. The practice also provided placements for the training of nursing students.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. Following an incident when tasks had not been addressed when a nurse went off ill the senior nurse was given access to all the nurses' tasks. If a nurse was off their tasks could now be re-allocated. Significant events and complaints were discussed at staff meetings. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they needed. This included appraisal and career development conversations. Staff had received annual appraisals in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.

Are services well-led?

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- There were positive relationships between staff and teams. Feedback from staff told us they were well supported by the GPs and practice manager. Staff commented that they felt communication could be improved particularly when changes were going to be made. The GPs and practice manager were aware of this and had organised a 'in hours' whole staff meeting in March 2018.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted interactive and co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of national and local safety alerts, incidents, and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems. Rooms were locked restricting unauthorised entry, however we observed two staff had not removed their smart cards from the computer when they had left a room.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. We received feedback from two members of the Patient participation Group (PPG). They said that they were informed of some decisions and changes that were to be made but were

Are services well-led?

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not always asked for their views when changes were being proposed. This was discussed and the PPG confirmed that they were now informed when changes were to be made.

- There was an active patient participation group. Some members of the PPG were health champions and supported with National Health Campaigns every year giving out leaflets etc. The PPG had helped at flu clinics and more recently informed patients of the prescription phone line closing, advising on alternative methods such as the internet and Pharmacy. They also held Macmillan Coffee mornings every year.
- The service was transparent, collaborative and open with stakeholders about performance.
- GPs in the practice took an active role in external leadership. For example; one GP was the Chair of the locality group for the CCG, one GP was the CCG medicines management lead and one GP had implemented a town wide 'Clinicians Learning Group' which met every two months.
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Continuous improvement and innovation

There were systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example; changes to the in house diabetes service had resulted in an increase in identifying patients with pre-diabetes and improved control for patients already diagnosed. The practice had identified 1127 patients with pre-diabetes. All the HbA1c diabetes blood test results were reviewed by the lead nurse before they were filed. This meant that if patients had deteriorating diabetes control or if it had improved it was being picked up much quicker and enabling staff to make plans to adjust treatment and/or plan the next follow-up in response.
- The diabetes consultant from the local hospital had visited the practice in February 2018. They reviewed the process and felt it was something that could be shared with other practice teams as not only did it seem to improve patient control but was also more efficient. The consultant and lead nurse had discussed the complex diabetic cases. They shared the primary care perspective and consultant suggestions on treatment which the consultant said was a very effective way of supporting primary care diabetes services.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.