The Doctors House - Marlow Medical Group

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Doctors House- Marlow Medical Group on 15 April 2015. Overall the practice is rated as good.

We found the practice to be good for providing effective, caring, well-led and responsive services. It required improvement for providing safe services. It was good at providing services for all the population groups including older people; people with long term conditions; mothers, babies, children and young people; the working age populations and those recently retired; people in vulnerable circumstances and people experiencing poor mental health.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from staff and patients, which it acted on.

Importantly the provider must:

- Ensure medicine management systems are reviewed and reflect national guidelines.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Summary of findings

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. This was because the practice medicine management systems did not always reflect national guidelines. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patient feedback on access was generally positive; with some patients' commenting it was easy to get an appointment. Some patients said it was difficult to get appointment with their named GP and others said it was difficult to get through the telephone system.

Summary of findings

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice sought feedback from staff and patients, which it acted on. The practice had patient participation group (PPG) in place. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits. The practice had a total of 2650 patients registered who were 75 and over and 2102 of these patients had received seasonal influenza vaccination in the period of September 2014 and March 2015.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. GPs had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. The practice had registers for patients needing diabetic care and asthma. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed. For example, 895 out of 1061 patients with diabetes had received an annual review of their condition in the period of 1st April 2014 and 31st March 2015. In the same period, 957 out of 1598 patients with asthma had received review of their health. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. Immunisation rates were high for all standard childhood immunisations. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice target group of women who were due smears in the last five years was 5998, out of which 5445 patients had received cervical screen in the last five years.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice had high proportion of working age population. The practice had 18409 patients who were aged between 19-74 years of age, out of which 5112 had received travel advice.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including patients with learning disability. For example, 26 out of 34 patients had received at least one consultation, telephone consultation, or home visit with a GP between April 2014 and March 2015. The practice offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including people with dementia). The practice kept a mental health register. 105 out of 174 patients had a current care plan either from the mental health team or a care plan agreed with their named GP. These patients were also signposted to local counselling services, such as healthy minds, for further advice and support. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice had diagnosed 102 patients with depression between the period of April 2014 to March 2015, out of which 90 patients had received a review within 10 to 56 days after diagnosis. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with eighteen patients visiting the practice and we received thirteen comment cards from patients who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about

NHS services and allows patients to make comments about the services they received). We also reviewed data provided in the most recent NHS GP patient survey.

Patients we spoke with were positive about the service they received from the practice. Patients told us staff were very helpful and accommodating. Patients were felt involved and supported in decisions about their care and were given a caring service.

One patient told us they were very happy practice nurses and said they never felt rushed when they were seen. Patients commented GPs and nurses explained procedures in great detail and were always available for follow up help and advice

We received further feedback from thirteen patients via comment cards. The comments cards reviewed were generally positive. Most patients commented how they were completely satisfied with the services provided by the practice. Patients described staff as professional and courteous. Four patients commented they found it difficult to get an appointment, but were happy with the care and treatment provided by the GPs and nurses when they were seen.

The 2014 GP patient survey showed 71% of patients found reception staff helpful and 83% of patients said the last appointment they got was convenient. Fifty seven per cent of patients described their experience of making an appointment as good and 71% of patients said they were able to get an appointment to see or speak to someone the last time they tried. Both these scores were lower than CCG average. Ninety three per cent of patients said they had confidence and trust in the last GP they saw and 99 % of patients said they had confidence and trust in the last nurse they saw. Both these scores were higher than CCG average.

Areas for improvement

Action the service MUST take to improve

- Ensure medicine management systems are reviewed and reflect national guidelines.

The Doctors House - Marlow Medical Group

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 second CQC inspector, practice nurse, pharmacist, a practice manager and expert by experience.

Background to The Doctors House - Marlow Medical Group

The Doctors House- Marlow Medical Group provides general medical services to approximately 28,000 registered patients. The practice is split over four sites, Marlow Surgery, Lane End Surgery, Hambleden Surgery and Hurley Surgery. This inspection was carried out at Marlow Surgery and Lane End Surgery.

Care and treatment is delivered by five male GPs and fourteen female GPs (across the four sites), practice nurses, health care assistants and phlebotomists. The practice also works closely with midwives, district nurses and health visitors. All consulting and treatment rooms are located on the ground floor, at both sites. The Marlow surgery operates from large purpose built building. The Marlow Surgery has a high number of patients registered who are over the age of 65 years old, with low deprivation scores.

The Marlow Surgery is open between 8am and 6.30pm on Monday to Friday and offers extended hours on alternate Tuesdays, Wednesdays and Fridays between 6.30pm to 8pm. The practice offers appointments on Saturday between 8am to 12pm.

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.

There were no previous performance issues or concerns about this practice prior to our inspection.

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

The practice provides services from the following four sites:

The Doctors' House- Marlow Surgery

Victoria Road

Marlow

Buckinghamshire

SL7 1DN

Lane End Surgery

Finings Road

Lane End

High Wycombe

HP14 3ES

Hambleden Surgery

The Surgery

Detailed findings

Hambleden

Henley on Thames

Oxon

RG9 6RT

Hurley Surgery

26 Shepherds Close

Hurley

Berks

SL6 5LY

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.

How we carried out this inspection

Before visiting we checked information about the practice such as clinical performance data and patient feedback. This included information from the clinical commissioning group (CCG), Chiltern Healthwatch, NHS England and Public Health England. We visited The Doctors House-Marlow Medical Group on 15 April 2015. During the inspection we spoke with GPs, nurses, health care assistants, dispenser, the practice manager, reception and administrative staff. We obtained patient feedback by speaking with patients, from comment cards, the practice's surveys and the GP national survey. We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, medicine alerts and national patient safety alerts as well as comments and complaints received from patients. National Institute of Heath and Care Excellence (NICE) guidance and reminders were cascaded by the GPs to relevant staff. These were also discussed at clinical governance meetings to ensure consistent information was given to patients. Patient safety alerts were received by the practice manager, and disseminated by email to clinical staff.

In the Lane End surgery, we saw the medicines alerts were received from Marlow surgery and found the last recorded alert was dated April 2013. Another alert, received online, was received in March 2015, but the actions taken had not been recorded.

Records were kept of significant events that had occurred and these were made available to us. Staff we spoke to were aware of their responsibilities to raise concerns, and the procedures for reporting incidents and significant events.

We reviewed safety records, incident reports and minutes of meetings for the last two years. These demonstrated that safety issues and incidents were discussed and the practice had managed these consistently over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last three years. We reviewed a number of of significant events, which had taken place in the last two years. These included, prescribing errors, unexpected death and methotrexate prescribing and monitoring. All incidents were logged with a summary of the event, learning achieved, actions agreed, and a review following the event.

Significant events and complaints were reviewed regular during clinical meetings. There was evidence that the practice had learned from these and that the findings were shared with all staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We also reviewed accident and complaint records and saw incidents had been recorded and if needed escalated to significant events which demonstrated the practice listened and had the intent to learn and make improvements. Safety alerts and information relating to patients was available on the electronic records for staff to readily access.

Multi-disciplinary practice meetings took place where attendance included clinicians from other disciplines such as palliative care nurses, community midwives or health visitors. Minutes from the meetings identified sharing information and reflective practice to reduce risk and improve services going forward.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. There was active engagement in local safeguarding procedures and the practice was involved in regular multi-disciplinary team meetings where patients at risk were discussed. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

At the Lane End Surgery we noted only the current temperatures were recorded in the dispensary fridge. Minimum and maximum temperatures had not been recorded. The dispensary fridge was equipped with an alarm that sounded if the temperature deviates from the required range.

The practice provided dispensing service from their Lane End Surgery, a branch surgery. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice.

At the Lane End surgery, the practice had one dispenser who was a lone worker. The dispenser told us they had access to a GP throughout the day and could raise concerns with them. We saw evidence the dispensing staff had completed appropriate qualification for this role; however, we found no evidence of regular supervision and continued professional development for this member of staff.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. In the Marlow surgery, both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

In the Lane End surgery we found records had not been kept of all prescriptions that had been issued to the dispensary and records had not kept for the prescriptions that had been distributed to the GP.

The practice held controlled drugs in the Marlow surgery. The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The practice kept a register for the controlled drugs and this was monitored regularly. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence that the lead had carried out an infection control audit and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular checks

Requires improvement

Are services safe?

in line with this policy to reduce the risk of infection to staff and patients. Or The practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. All equipment had been calibrated and PAT tested on annual basis.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager told us they regularly monitored the staffing mix and use the appointment system and the Rapid Access Clinic (RAC) system to aid this planning.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw evidence that the practice had completed some risk assessments. These included, risk assessment of fire and legionella. Any risks were identified and action plans were put in place to minimise risk.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an external defibrillator (used to attempt to restart a person's heart in an emergency). All staff we spoke with knew the location of this equipment.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use at both Marlow surgery and Lane End Surgery.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, flood, fire, unplanned sickness and adverse weather. The document also contained relevant contact details for staff to refer to including the telephone numbers of all staff and those of other practices within the area.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. The GPs told us new guidelines were disseminated and discussed informally and during team meeting, and required actions agreed.

The practice used an electronic system called CISES, where they received updates on all new clinical guidance and best practice on a regular basis. Any changes were then shared with the practice team. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice had registers for patients needing diabetic care, dementia, cardiovascular disease and patients with chronic obstructive pulmonary disease. This helped to ensure each patient's condition was monitored and that their care was regularly reviewed. Monthly multi-disciplinary team meetings were held and they included other professionals involved in the individual patient's care.

All GPs we spoke with used national standards for urgent referrals seen within two weeks, and we saw national templates were saved on the shared drive for easy access. Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. We saw several examples of two audits which had been carried out and the practice could demonstrate that they had improved outcomes for patients over time. These included audits for prescribing, clinical coding, audiology, referrals, and metformin. We saw evidence that key points had been summarised and learning was shared with staff.

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 practice achieved 98% on their QOF 2014 score compared to a national average of 96%. We saw the practice did well in clinical areas, such as mental health, asthma and dementia.

The practice had achieved and implemented the gold standards framework for end of life care. It had a palliative care register and had regular multidisciplinary meetings to discuss the care and support needs of patients and their families. We noted that the needs of patients who had a new diagnosis of cancer were also discussed by the team at this forum.

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services. If information was deemed to be particularly

Significant, it was flagged up so it was immediately visible to the viewer. This included information such as whether a person was a carer or a vulnerable person.

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 the General Medical Council (GMC) GP continue to practice and remain on the performers list with NHS England).

We noted a good skill mix among the GPs with specialist interest and training in Caldicott guardian, prescribing, research, leadership, clinical governance and safeguarding. We saw evidence two GPs had completed courses in diabetes and international normalization ratio (INR) testing.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our discussions with staff confirmed that the practice was proactive in providing training and funding for relevant courses. The training record made available to us showed staff had received training in areas such as, safeguarding, infection control, equality and diversity, fire safety and information security. There were systems in place to disseminate relevant learning through a structure of team meetings. For example, team meeting minutes and health promotion information was stored on a central system, and all staff had access to this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were aware of their responsibility in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings once a month to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and health visitors and decisions about care planning were documented in the meeting minutes. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used electronic systems to communicate with other providers. Electronic systems were in place for making referrals, and the practice made referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and patients welcomed the ability to choose their own appointment dates and times.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice sent out regular newsletters to share information about relevant health topics and what was happening in the practice. For example, the Spring 2015 edition newsletter, included information on family and friends test, GP recruitment, the new WebGP service, and extended hours.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the GPs and nursing staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw evidence the patient and their family had been involved, and the patient's decisions were respected.

The clinical staff spoke with confidence about Gillick competency assessments of children and young people,

which were used to check whether these patients had the maturity to make decisions about their treatment. All staff we spoke with understood the principles of gaining consent including issues relating to capacity.

Health promotion and prevention

There was health promotion material available in the waiting area. This included information on, cancer, diabetes, memory loss, diabetes and sexual transmitted diseases. There was also information about services to support them in, for instance, Marlow Age Concern. This organisation is an independent charity, which helped elderly patients in a number of ways. This included providing transport from the patient's home to the practice or to the hospital, day centre for socialising and trained physiotherapist was available to provide assistance to patients who had suffered from stroke. The practice also used their website for health promotion. This included information on, diabetes, sexual health, asthma, first aid and self-help. Patients were encouraged to take an interest in their health and to take action to improve and maintain it.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with mental health problems and 105 out of 174 patients had a current care plan either from the mental health team or a care plan agreed with their named GP. These patients were also signposted to local counselling services, such as healthy minds, for further advice and support.

The practice also kept registers for patients with diabetes, dementia, asthma and COPD, and reviewed these patients care regularly. For example, 895 out of 1061 patients with diabetes had received an annual review of their condition in the period of 1st April 2014 and 31st March 2015. In the same period, 123 out of 161 patients with dementia had received an annual review of their health.

The practice data for 2014 showed 83.8% of patients with diabetes had a dietary review in the last 12 months, this was better than the national average of 82.2%. The number of newly diagnosed diabetes patients who had been referred to the education programme within nine months was 89.6% and again the practice had performed better than the national average of 84.4%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all childhood immunisations was approximately 95% and was above average for the CCG. There was a clear policy for following up non-attenders by the practice nurse. In 2013/14 the practice vaccinated 74.7% of patients over 65 years old with the flu vaccine. This was better than the national average of 72.99%. For patients within the at risk groups, 52.62 of patients were vaccinated in the same period. This was slightly lower than the national average of 53.22%.

In 2013/14 the number of patients with a smoking status recorded in their records was 84.31% in comparison to national average of 86.63%. Of these patients 100% of patients had received advice and support to stop smoking which was higher than the national and CCG average. The practice's performance for cervical smear uptake was 89% and this was better than the national and CCG average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and family and friends test. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, 2014 national GP survey showed 99% of patients said the nurse they saw was good at treating them with care and concern and 76% of patients said the GP they saw was good at treating them with care and concern. Ninety three per cent of patients said they had trust and confidence in the GP they saw.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive, where patients commented they found it difficult to get an appointment. All four of these patients commented they were happy with the treatment and care they received from the practice. All patients told us they were satisfied with the care provided by the practice and said staff were caring, courteous and professional.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Reception staff told us that facilities were available for patients to talk confidentially when they were at the reception desk. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. Staff we spoke with were aware of their role in relation to confidentiality.

During our visit we saw conversation between patients and staff in reception areas could be overheard. The practice was aware of this issue and had discussed this during a team meeting. The practice had decided to place a signs to ask patients to stay behind a certain point and for staff to inform patients if they wished to discuss any matter in privacy, and to notify staff if they wished to discuss speak to staff in privacy.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager would investigate these and any learning identified would be shared with staff.

The practice displayed message on the waiting area screen stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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 GP national patient survey showed 87% of patients felt the GP was good at explaining treatment and results and 75% of patients said the GP involved them in care decisions. Eighty nine of per cent of patients said the GP they saw was good at giving them enough time. Eighty nine per cent of patients stated the nurse they saw was good at giving them enough time and 89% patients said was good at listening to them. Both these results were above average compared to national average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. The practice website carried a facility to translate information into over 50 different languages.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

New patients who registered at the practice were asked if they had a carer or if they were a carer and if the person they cared for was registered at the practice. This information was put onto the patient's record to alert practice staff so that appropriate support could be given. Information was available in the waiting room and on the practice website, which sign posted people to a number of support groups and organisations for carers.

Staff told us families who had suffered bereavement were called by their usual GP. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs. Information on local bereavement services was available in the waiting area.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

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.

A range of clinics were offered to patients, which included antenatal, family planning and minor surgery. The practice ran regular GP specialist clinics for long-term conditions. These included asthma, diabetes, chronic obstructive pulmonary disease (COPD). The practice also offered a number of in house services. These included, spirometry niox testing, phlebotomy, audiogram/tympanogram, near patient testing and international normalization ratio (INR) testing.

The practice used the choose and book system to make referrals to secondary (hospital) services. This ensured the patient had influence over where their care and health care needs were met. The practice had a comprehensive system for making referrals. This was managed through an administrative referrals team within the practice. There was a clear policy that outlined the process of making referrals such as the investigations that a clinician needed to have carried out before making a referral.

Tackling inequity and promoting equality

The Doctor's House- Marlow Medical Group occupied a purpose built building. The doorways were wide and there was space for wheelchairs and mobility scooters to turn. The surgery had large consultation rooms spread throughout the ground floor. The practice had reserved car spaces for patients with disabilities. Adapted toilet and washroom facilities were available for patients with disabilities. The practice had installed two self-check in screens. We saw one was lowered to ensure patients with limited mobility were able to easily access this service.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

Access to the service

The practice offered a range of appointments to patients every weekday between the hours of 8am and 6.30pm. The practice opened for extended hours on alternate Tuesdays, Wednesday's and Thursday's and offered early morning appointments on Saturday from 8am to 12pm, where pre-bookable appointments could be made. This benefitted patients who worked full time.

Appointments could be booked in person, via telephone or via an internet appointment system for patients who had registered their details for this method. Telephone consultations were available for each GP at allotted times throughout the day. A GP commented this was particularly useful for patients with work commitments.

Patient feedback on access was generally positive; with some patients' commenting it was easy to get an appointment. Some comments were less positive. Some patients said it was difficult to get appointment with their named GP and others said it was difficult to get through the telephone system. All patients we spoke with confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice.

The 2014 national GP survey showed 73% of patients were satisfied with telephone access, which was slightly lower than the national average of 75%. Sixty per cent of patients rated their overall experience of making an appointment as good and 50% of patients said they were able to see a nurse or GP on the same or next day and this was in line with the national average.

In response to feedback received from patients, the practice reviewed their systems and made a number of changes. The practice had introduced the 'Rapid Access

Good

Are services responsive to people's needs?

(for example, to feedback?)

Clinic' (RAC) system to improve access for patients. Through this system patients were able to see a GP or Nurse on the same day and enabled the practice to create more appointments. A GP and the practice manager reviewed the appointment system on a daily basis. Furthermore an audit on appointment availability had been completed to aid planning and improvement.

The practice had introduced Surgery Pods, to help manage demand and improve patient accessibility. Patients were able to use the Surgery Pods to take their blood pressure, weigh themselves and answer a number of health related surveys. The information was then recorded and posted immediately to the practice clinical system and patients were alerted if they were required to follow up with a member of the clinical team.

The practice had also introduced the 'WebGP' system and used this system to inform patients on self-help, provided advice on the use of alternative services and allowed them to consult electronically with their GP. In addition, the practice was actively looking to recruit GP's nurses and HCA's, in order to offer more appointments and improve accessibility.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were offered to patients who were unable to visit the practice.

Listening and learning from concerns and complaints

Patient's comments and complaints were listened to and acted upon. Information on how to make a complaint was provided on the practice website and leaflet. The complaints procedure provided further information on how to make complaint on someone's behalf and who at the practice would deal with the complaint. The practice had a clear complaints procedure and this was displayed in the waiting area. This allowed patients to make an anonymous complaint as they were able to provide the information discreetly.

The practice kept a record of all written complaints received. We reviewed a sample of complaints, and found the complaints had been investigated and responded to, where possible, to the patient's satisfaction. The outcomes of complaints, actions required and lessons learned were shared with the staff during team meetings.

Staff told us complaints were openly discussed to ensure all staff were able to learn and contribute to any improvement action that might be required; and this was reflected in some of the records we looked at.

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 be the local GP training practice of choice and to deliver high quality and safe care to their patients. We found the vision and practice values were part of the practice's strategy. The practice vision included to provide an appropriate and rewarding experience for our patients whenever they need our support. The practice operated with a set of values that had been had been shared with staff and staff were encouraged to comment upon them. The core values included; openness. Fairness, respect and accountability. We found staff demonstrated the values of the practice.

The practice had a documented business development plan in place, which had been regularly reviewed in the last two years. The business development focused on areas such as, staffing, skill mix between clinical and non-clinical staff, communication, premises and profitability and a changing market place. The practice regularly discussed and monitored the development plan to ensure objectives were being achieved.

All the staff we spoke with knew and understood the vision and values of the practice and their responsibilities in relation to them. Staff we spoke with said they enjoyed working for the practice and that everyone was signed up to the aims and objectives.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at GP partner team meetings and action plans were produced to maintain or improve outcomes.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and one of the GP partners was the lead for safeguarding. The GPs had clinical lead roles in prescribing, mental health, Caldicott guardian and clinical governance. The nursing team had expertise and lead roles in asthma, dietary advice and cervical smears. All staff we spoke with were clear about their own roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns.

A GP partner held lead responsibility within the practice as the Caldicott Guardian and was clear about their role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place for confidentiality, data protection and information sharing.

We saw from minutes that team meetings were held regularly, at least monthly. These included, clinical meetings protected learning time meetings, team meeting and whole practice meeting. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as recruitment and induction policies which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on health and safety, medical records and patient confidentiality at work. Staff we spoke with knew where to find these policies if required.

Staff also spoke positively about the practice and how they worked collaboratively with colleagues and health care professionals; for example, midwives and health visitors.

Are services well-led?

Good

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

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

The practice gathered feedback from patients through the NHS patient survey; family and friends test survey, suggestion box and complaints received. The practice had received good response in the February 2015 family and friend test survey. Most of the feedback was very positive, and patients complimentary of the staff. Eighty five per cent of patients said they were extremely likely or likely to recommend the practice.

The practice had a patient participation group (PPG) in place, with approximately 18 patients. PPG's work in partnership with their practice contribute to the continuous improvement of services and foster improved communication between patients and the practice. The PPG members met twice every year. There was also a virtual PPG of approximately 158 members who the PPG made contact with regularly to involve in decisions about the running of the practice.

The PPG members told us the practice used the PPG meetings as forum to share information about the practice. We reviewed the February 2015 PPG meeting minutes, and saw a GP partners and the practice manager discussed a number of recent events and issues affecting the surgery. These included; the Care Quality Commission (CQC) intelligence monitoring, family and friends test, work load and proactive coordinated care project.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management team. For example, some staff had reported they did not feel listened to and had said communication could be better. The management team reviewed these comments in the team meetings and following discussion put systems in place to address these concerns. This included, an introduction of the 'collaborator' system, and used this to disseminate important information and encourage discussion. The staff we spoke with told us this system worked very well.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. There were high levels of staff satisfaction.

Management lead through learning and improvement

There was a strong focus on improvement and learning shared by all staff. The staff we spoke with demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Chiltern Clinical Commissioning Group (CCG), completing online learning courses and reading medical journals. The management team had attended a leadership course.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was supportive of training. For example, one member of staff had requested further training on the new computer system and this had been provided by the practice.

The practice had completed reviews of significant events, complaints and other incidents which included lessons learned. We saw evidence that significant events were discussed at practice meetings and the lessons learned were shared with staff to ensure the practice to ensure the practice improved outcomes for patients.

The practice was a GP training practice and had been rated as an outstanding training practice in an inspection that took place on June 2014.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment must be provided in a safe way for service users. The registered person must comply with the proper and safe management of medicines. Regulation 12 (2) (g).