Marlborough Surgery

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?	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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Overall summary

Letter from the Chief Inspector of General Practice

We carried out this comprehensive inspection on 16 February 2016.

Overall, we rated this practice as good.

Our key findings were as follows:

- The practice provided a good standard of care, led by current best practice guidelines. A programme of clinical audit was used to identify where patient outcomes could be improved.
- Staff understood and fulfilled their responsibilities to raise concerns. Information about safety was monitored, appropriately reviewed and addressed.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- The practice had comprehensive policies and procedures to govern activity, which were reviewed regularly.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice was proactive in the promotion of good health and management of long term conditions. Staff communicated within multi-disciplinary teams to manage complex conditions.
- There was a clear leadership structure and staff felt supported by management. Staff felt confident in their roles and responsibilities.
- The practice worked with the Patient Participation Group (PPG) to listen to feedback and instigate change.

We saw one area of outstanding practice:

- The practice had invested in a blood pressure machine and scales in reception for patients to use, with instructions, or support from staff. This could either opportunistically identify areas for concern, or patients

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attending for long term condition reviews could collect these results before their appointment, leaving more time to discuss their condition once they were with a member of clinical staff.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood their roles and responsibilities in raising concerns, and reporting incidents. Lessons were learned from incidents, and we found evidence that incidents had been reported, discussed and reflected upon. This included required actions and who was responsible for completing these. There were sufficient emergency and contingency procedures in place to keep people safe. There were sufficient numbers of staff with an appropriate skill mix to keep patients safe. The practice had assessed risks to those using or working at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the Quality and Outcomes Framework (QOF) showed that the practice performed at or above Clinical Commissioning Group (CCG) averages. Systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. The practice was proactive in the promotion of good health and patient involvement. Patients with some long term conditions were given individual care or management plans and staff communicated within multi-disciplinary teams to manage complex conditions. Staff were supported within their roles to develop their skills, through a system of protected learning time, appraisals, and identified learning needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Feedback from patients about their care and treatment was positive. Patients said they were treated with care and concern. We observed a patient-centred culture and staff promoted this as the ethos of the practice. Staff were motivated and inspired to offer kind and compassionate care. In patient surveys, the practice scores for how caring patients found the practice were at or above average compared to local and national survey results.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had a good overview of the needs of their local population, and was proactive in engaging with the Clinical Commissioning Group (CCG) to secure service improvements. The practice was located within a purpose built building, had sufficient facilities and was well equipped to meet patients need. Information was provided

Summary of findings

to help patients make a complaint, and there was evidence of shared learning with staff. The majority of feedback was positive around access to the service, apart from some negative feedback around ease of use of the practice telephone system.

Longer appointments were made available where necessary, for instance patients with learning difficulties, or older people with complex health needs or mobility issues. The practice participated in extended hours opening, and recently in response to patient demand offered additional appointments with health care assistants or a GP from 7:30am on Thursday.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a forward plan to work to with clear aims and objectives. The practice had a well-developed vision and values which staff were familiar and engaged with. The practice had a Patient Participation Group (PPG) and was able to evidence where changes had been made as a result of PPG and staff feedback. Staff described the management team as available and approachable, and said they felt highly supported in their roles. The practice had a number of policies and procedures to govern activity and held regular staff and management 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 people. The practice held palliative care and multi-disciplinary meetings regularly to discuss those with chronic conditions or approaching end of life care. Information was shared with other services, such as out of hours services and district nurses. Nationally returned data from the Quality and Outcomes Framework (QOF) showed the practice had good outcomes for conditions commonly found in older people.

The practice participated in the local Admission Avoidance service, where vulnerable patients living in care homes, housebound or at high risk of admission were cared for by a GP in conjunction with Advanced Nurse Practitioners. These patients were monitored and visited, ensuring assessments and care plans were in place when required. All care home patients were reviewed annually by their named GP, which included dementia and mental health reviews, and medication reviews. Housebound patients received care reviews at home from the practice nurses.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. Staff implemented clinics to minimise patient need for attendance, for instance patients with multiple conditions. Staff ensured through joint working that housebound patients had the same access to reviews through home visits.

Staff skill mix had been reviewed and was mapped to patient need. Lead clinicians had been identified for all the major chronic disease areas, such as asthma and diabetes. Practice nurses and GPs worked collaboratively to implement annual chronic disease reviews. Patients with long term conditions were monitored and discussed at multi-disciplinary clinical meetings so the practice was able to respond to their changing needs. Non- attendance at clinics was followed up, and reminders issued. Outcomes were monitored through clinical audits. Data showed the practice was proactive in managing long term conditions. Diabetes indicators were all above national averages. For instance QOF data from 2014-15 showed the percentage of diabetic patients having a record of a foot check in the previous 12 months was 90.94%, above the national average of 88.3%.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place to identify children who may be at risk. The practice monitored levels of children's vaccinations and attendances at A&E. Regular multidisciplinary meetings were held to review children on the safeguarding register. Immunisation rates were around average for all standard childhood immunisations. Weekly Baby Clinics were run at the surgery by the local health visitor, along with the GP lead. These were combined with nurse-led Childhood Immunisation clinics, to minimise the need to attend multiple appointments at the practice. The under-five's had protected appointment slots with same day access to a GP. Young people could access family planning and sexual health advice. In the school holidays the practice provided an additional asthma annual review clinic so that school age children could attend without missing school.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working age people (including those recently retired and students). The needs of the working population had been identified, and services adjusted and reviewed accordingly, for instance extended hours appointments were available later in one evening and earlier one morning. Patients could also access a Saturday morning surgery. Patients could access a variety of services during these times, such as NHS health checks and contraceptive services. Routine appointments could be booked in advance, or made online. Repeat prescriptions could be ordered online. Electronic prescribing meant prescriptions could be sent electronically to a pharmacy of choice, which could be out of the area, for example close to where the patient worked, which made it more convenient to collect medication.

Telephone appointments were available. An on-call duty doctor system meant urgent calls could be triaged, and the patient either given telephone advice, or allocated a same day appointment. The practice carried out NHS health checks for people of working age, and actively promoted screening programmes such as for cervical cancer.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people living in vulnerable circumstances. The practice had a register of those who may be vulnerable, including those with learning disabilities, who were offered annual health checks. New patients who may be

vulnerable were identified through health checks and screening questionnaires. The practice offered permanent or temporary registration for patients from women's refuge and sheltered housing services.

Patients or their carers were able to request longer appointments if needed. The practice had a register for looked after or otherwise vulnerable children and also discussed regularly any cases where there was potential risk or where people may become vulnerable. The computerised patient plans were used to flag up issues where a patient may be vulnerable or require extra support, for instance if they were a carer. Carers could then be signposted to support organisations. Staff were aware of their responsibilities in reporting and documenting safeguarding concerns. Vulnerable patients were discussed at quarterly safeguarding meetings or fortnightly clinical meetings according to need.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice made referrals to and worked with other local mental health services as required.

Patients with mental health issues or dementia were coded on their records so they could be offered extra support to access services and health checks. These patients were offered an annual review. The GP mental health lead followed up patients who did not respond to their appointment invites. The practice was proactive in dementia screening and review for at risk patients.

The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the previous 12 months was above the national average of 88.47%, at 100%.

Summary of findings

What people who use the service say

For the latest NHS England GP Patient Survey, 289 survey forms were distributed and 99 were returned. This represented approximately 0.97% of the practice's patient list. The survey responses showed the following:

What this practice does best

92% of respondents were able to get an appointment to see or speak to someone the last time they tried

Local (CCG) average: 86% National average: 85%

74% of respondents usually waited 15 minutes or less after their appointment time to be seen

Local (CCG) average: 68% National average: 65%

98% of respondents said the last nurse they saw or spoke to was good at explaining tests and treatments

Local (CCG) average: 94% National average: 90%

What this practice could improve

54% of respondents with a preferred GP usually got to see or speak to that GP

Local (CCG) average: 61% National average: 59%

72% of respondents found it easy to get through to this surgery by phone

Local (CCG) average: 79% National average: 73%

83% of respondents found the receptionists at this surgery helpful

Local (CCG) average: 90% National average: 87%

We spoke with six patients as part of the inspection, and two members of the Patient Participation Group (PPG). We also collected 20 CQC comment cards which were sent to the practice before the inspection, for patients to complete.

Almost all patient feedback and comment cards indicated patients were happy with the service provided. Patients said they were treated with dignity and respect, and that all staff were very caring. Patients were given sufficient time during appointments. Patients said staff were pleasant, friendly and welcoming. Patients said that the facilities at the practice were good, and they were confident with the care provided, and were involved in their treatment options. A minority of negative feedback concerned how easy it was to get through on the practice phones, which had been identified by the practice as an area they wished to improve, and waiting times for appointments.

Outstanding practice

- The practice had invested in a blood pressure machine and scales in reception for patients to use, with instructions, or support from staff. This could either opportunistically identify areas for concern, or patients attending for long term condition reviews could collect these results before their appointment, leaving more time to discuss their condition once they were with a member of clinical staff.

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Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a specialist advisor GP, and a Practice Manager.

Background to Marlborough Surgery

Marlborough Surgery provides general medical services (GMS) to approximately 10,200 patients in the catchment area of Seaham and surrounding villages. The practice is located within a purpose built primary care centre. This is the Durham Dales, Easington and Sedgefield Clinical Commissioning Group (CCG) area. The practice team consists of five partner GPs, two salaried GPs, two nurse practitioners, two practice nurses, and two healthcare assistants. These are supported by a practice manager, and a team of reception, and administrative staff. The practice is a training practice and provides placements to one GP registrar. These are fully trained hospital Doctors who spend an additional three years training to become primary care GP's.

The practice core hours are between 8am and 6pm on Mondays to Fridays. Additional extended hours are available between 8am and 12pm on Saturdays, and from 6pm until 8:30pm on Mondays. All patients living in the area can access the Saturday morning appointments on a walk-in basis through agreement with the CCG. Recently in response to patient demand the practice offered additional appointments with health care assistants and GPs from 7:30am on Thursday.

The practice has higher levels of deprivation compared to the England average. There are higher levels of people with daily health problems, and claiming disability living allowance. The practice has opted out of providing Out of Hours services, which patients access via the 111 service. The practice is part of the South Durham Health CIC federation.

Why we carried out this inspection

We carried out the inspection 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

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?

Detailed findings

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

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

Before our inspection we carried out an analysis of data from our Intelligent Monitoring system. We also reviewed information we held and asked other organisations and key stakeholders to share what they knew about the service. We reviewed the practice's policies, procedures and other information the practice provided before the inspection.

We carried out an announced inspection on 16 February 2016.

We reviewed all areas of the practice site, including the administrative areas. We sought views from patients both face-to-face and via comment cards. We spoke with management staff, GPs, nursing staff, PPG members, and administrative and reception staff.

We observed how staff handled patient information received from the out-of-hours' team and patients ringing the practice. We reviewed how GPs made clinical decisions. We reviewed a variety of documents used by the practice to run the service.

Good

Are services safe?

Our findings

Safe track record and learning

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

• Staff understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses. Staff said they felt encouraged to report incidents, Staff told us they would inform the nominated person of any incidents, and they would be supported in recording these.

• The practice carried out a thorough analysis of the significant events, which recorded the circumstances, learning points and required actions.

We reviewed safety records, incident reports, national patient safety alerts and minutes of meetings where these were discussed. Lessons were shared to make sure action was taken to improve safety in the practice, such as reviewing clinical templates or refreshing procedures.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. There were lead members of staff for children's and adult's safeguarding, who staff were aware of. The practice participated in joint working arrangements and information sharing with other relevant organisations including regular meetings with health visitors. This included the identification, review and follow up of children, young people and families living in disadvantaged circumstances, including children deemed to be at risk. Staff demonstrated they understood their responsibilities and had received training relevant to their role. Computerised patient notes were coded to flag up safeguarding concerns.
- Notices in the waiting room and on consulting room doors advised patients that they could request a chaperone. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS check). (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. There was an infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. More frequent checks were not undertaken as the infection control lead did not have protected time to carry out this role. We did find some out of date sterile items including speculums, scissors and tweezers. Staff told us they no longer used these items as they used disposable equivalents, but these items had not been removed or disposed of.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Prescription pads were securely stored and there were systems in place to monitor their use. A nurse practitioner had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. This involved additional training updates, mentorship and support. Patient Group or Patient Specific Directions had been adopted by the practice to allow nurses or health care assistants to administer medicines in line with legislation.
- We reviewed personnel files and found that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Good

Are services safe?

However there was no risk assessment in place for how often DBS checks were revisited, or when staff were asked to sign a declaration stating there had been no changes.

Monitoring risks to patients

- There were some procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy and procedures available. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice also had other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and electrical equipment, but not all risks had been identified, monitored or reviewed. Fire safety, maintenance and drills were managed by the building's owners, but the practice did not actively check all necessary checks and procedures were in place, so were unaware of the level of risk. The last fire drill had been over 18 months previously.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Staff said their team levels were sufficient to provide services and cover for annual leave or busy periods.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- Staff received life support training and there were emergency medicines available.
- The practice had a defibrillator and oxygen available on the premises which were checked and serviced regularly.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.
- The practice had a business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Additional procedures were published for staff including patient emergency handling and emergency call handling protocols.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met peoples' needs. NICE guidance was disseminated through team meetings which ensured staff were aware of information relevant to them. NICE guidelines were regularly discussed at clinical meetings, including how these linked to personalised care plans and specific templates for care.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). In 2014-15 the practice achieved 95.4% of the total number of points available. Outcomes for patients were generally similar to national averages.

For example, data from 2015 showed;

• The percentage of patients with diabetes having a flu vaccination in the last 12 months was 96.94%, similar to the national average of 94.45%.

• The percentage of patients with hypertension having regular blood pressure tests was 80.26%, the national average being 83.65%.

• The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the previous 12 months was above the national average of 88.47%, at 100%.

The practice participated in applicable local audits and national benchmarking. Clinical audit findings were used by the practice to improve patient care. For instance, the practice could demonstrate through completed audit a reduction in avoidable delays in cancer diagnosis and referral. Other audits included a review of antibiotic use, and a review of oral contraceptive use in patients with a high BMI. Findings were discussed at clinical meetings and through peer review.

The practice participated in the local admission avoidance service, where vulnerable patients living in care homes, housebound or at high risk of admission were cared for by a GP in conjunction with Advanced Nurse Practitioners. These patients were monitored and visited, ensuring assessments and care plans were put in place when required. All care home patients where are reviewed annually by their named GP, which included dementia and mental health reviews, medication reviews and, when appropriate, review of do not attempt resuscitation (DNAR) decisions. Housebound patients received care reviews at home from the practice nurses.

Regular multi-disciplinary meetings were held to discuss the needs of patients, for instance on the unplanned admissions register, requiring palliative care, or with long-term conditions to ensure their needs assessment remained up to date. Nursing staff implemented long-term condition clinics to ensure patients were given appropriate reviews and support.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed members of staff that covered such topics as health and safety, information management and confidentiality. New members of staff were given additional support and mentoring. The practice had appropriate recruitment policies.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff e.g. for those reviewing patients with long-term conditions, administering vaccinations and taking samples for the cervical screening programme. Staff told us they were well supported with specific learning needs.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Clinical staff had access to clinical supervision and one to one support from GPs.
- Staff received basic training that included: safeguarding, fire procedures, basic life support and information

governance awareness. Staff had access to and made use of e-learning training modules and in-house training, further role specific training, and training accessed via the CCG.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring people to other services. Information was available electronically to out of hours services and ambulance services to help continuity of care.
- The practice had an appropriate recall system for tasks such as long term condition reviews, and medication reviews. The practice had support one day a week from the CCG pharmacist, and additional support for 20 hours a week from a locum pharmacist to carry out medication reviews and review prescribing.
- Staff had processes to follow on receiving results to ensure these were entered onto the patient record in a timely fashion and necessary actions were taken according to the result.
- Staff worked together and with other health and social care services, such as district nurses and advance nurse practitioners to understand and meet the range and complexity of people's needs and to assess and plan ongoing care and treatment. This included when people moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a regular basis, where people with long term conditions, at risk of admission and requiring palliative care were discussed to ensure their needs assessment and care plans were kept up to date. Regular clinical meetings took place within the practice.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood and had been trained in the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, where appropriate, recorded the outcome of the assessment using templates on the patients record.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking or alcohol cessation. Patients were then signposted to the relevant service.
- Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for people aged 40–74. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified. Health checks were used to opportunistically identify patients who may need extra support, for example those with caring responsibilities.
- Immunisation rates were around average for all standard childhood immunisations. Antenatal clinics were held weekly, and patients could access contraception and sexual health clinics.
- The practice's uptake for the cervical screening programme was 81.03%, similar to the national average of 81.83%. Patients who did not attend for their cervical screening test were sent reminders. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening.
- There was a blood pressure machine and scales in reception which patients could use, with instructions, or support from staff. This could either opportunistically identify areas for concern, or patients attending for long

Good

Are services effective?

(for example, treatment is effective)

term condition reviews could collect these results before their appointment, leaving more time to discuss their condition once they were with a member of clinical staff.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 20 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

The latest NHS England GP Patient Survey of 99 responses showed that patient satisfaction was similar to or slightly above local and national averages for how they felt they were treated. For instance,

- 89% of patients said the last GP they saw or spoke to was good at giving them enough time

Local (CCG) average: 90% National average: 87%

- 91% said the last GP they saw or spoke to was good at listening to them

Local (CCG) average: 91% National average: 89%

- 90% say the last GP they saw or spoke to was good at treating them with care and concern

Local (CCG) average: 89% National average: 85%

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and national average of 86%.
- 90% said the last GP they saw was good at involving them in decisions about their care (CCG average 85%, national average 82%)
- 91% said the last nurse they saw was good at involving them in decisions about their care (CCG average 90%, national average 85%)

Staff told us that translation services were available for patients who did not have English as a first language. There was a hearing loop at reception.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations. There was some information on bereavement services in reception, and doctors could refer patients to local counselling, or mental health services. The practice kept registers of groups who needed extra support, such as those receiving palliative care and their carers, and patients with mental health issues, so extra support could be provided.

Staff told us that if families had suffered bereavement, they were offered additional support and contact through the co-ordinating GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local CCG to improve outcomes for patients in the area, and had recognised the needs of different groups in planning its services, for instance in participating in vulnerable adults additional services including reviews for patients in care homes.

- Telephone consultations, pre-bookable or extended hours appointments were available, to assist those who would otherwise struggle to access the surgery, for instance the working population.
- Online medication reviews were available, which the patient could fill in and the doctor assess without need for the patient to attend surgery. Electronic prescribing meant patients could then pick up their medicines at a convenient point, for instance a pharmacy close to their work.
- Children under the age of five had same day access to a GP. Vulnerable patients or those at high risk of admission were identified on their notes so could be offered appropriate access at the first point of contact. Longer appointments could be made available for those with complex needs.

The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions. The practice was located within a purpose-built building which accommodated the needs of people with disabilities, incorporating features such as accessible toilet facilities and automatic doors. Treatment and consulting rooms were accessed via a lift.

Access to the service

The practice core hours were between 8am and 6pm on Mondays to Fridays. Additional extended hours were available between 8am and 12pm on Saturdays, and from 6pm until 8:30pm on Mondays. Additional appointments with health care assistants or a GP were available from 7:30am on Thursdays. All patients living in the area could access the Saturday morning appointments through agreement with the CCG.

Information was available to patients about appointments on the practice website. Information included how to arrange urgent appointments and home visits and how to book appointments. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. Appointments could be made in person, by telephone or online. Repeat prescriptions could also be ordered online. A mix of pre-bookable and 'on the day' appointments were available.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was in some areas comparable to local and national averages:

- 81% of patients were satisfied with the practice's opening hours compared to the CCG average of 80% and national average of 75%.
- 92% of patients were able to get an appointment to see or speak to someone the last time they tried, compared to the CCG average of 86% and national average of 85%.

However there were some areas of lower satisfaction including ongoing issues with the buildings phone system which the practice were trying to address, and access to a GP of choice:

- 72% patients said they could get through easily to the surgery by phone (CCG average 79%, national average 73%).
- 54% patients said they usually got to see or speak to the GP they prefer (CCG average 61%, national average 59%).

People told us on the day of the inspection that they were able to get appointments when they needed them. The numbers of book on the day or pre-bookable appointments were adjusted according to predicted need. Staff numbers and required skill mix were planned advance.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

We looked at a summary of complaints made in the last 12 months, and could see that these had been responded to with an explanation and apology, and investigated as a

Good

Are services responsive to people's needs?

(for example, to feedback?)

significant event where necessary. We could see where corrective actions were taken, such as refresher training for staff. Patients we spoke with said they would feel comfortable raising a complaint if the need arose.

Are services well-led?

Good

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

Our findings

Vision, Strategy and Culture

The practice had a clear vision, aims and objectives contained within their statement of purpose. Staff were familiar with and engaged with the values and ethos of the practice. Staff we spoke with agreed that communication within their own teams and as a practice was good, and they formed a strong cohesive team, where people worked flexibly and supported one another. The practice had managed change well, while maintaining and improving staff morale. The practice manager told us how they now wished to develop more strategic long term aims. Projects included developing a new brand and logo, and developing the practice website to be more user friendly.

Staff had individual objectives via their appraisals, such as clinical staff looking to develop their knowledge in a certain area to be able to offer additional service. Staff described the appraisal process as useful and stated they were able to identify and follow up on learning objectives through these. Staff told us that regular team meetings were held, and we saw this from meeting minutes. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did. There was a clear leadership structure in place and staff felt supported by management.

Governance Arrangements and Improvement

Staff were clear on their roles and responsibilities, and felt competent and trained in their roles. The practice had a number of comprehensive and regularly reviewed policies and procedures in place to govern activity. These included a chaperone policy, safeguarding policies, and human resources policies. These were available to staff via the shared computer system, although not all staff were clear on how to access this information. The practice had a whistleblowing policy which was also available to all staff within the practice.

The practice used the Quality and Outcomes Framework (QOF) to measure performance. The practice regularly reviewed its results and how to improve, and was proactive in using patient contact to promote additional screening or review services. The practice reviewed its QOF activity monthly to plan areas where they needed to target resource. We saw evidence that they used data from various sources including patient surveys, incidents, complaints and audits to identify areas where improvements could be made. These included audits on necessary follow ups after new patient health checks, taken appointment length for a GP, and patient attendance at the Urgent Care Centre located in the same building.

The practice had identified lead roles and deputies for areas such as, safeguarding, chronic disease management and infection control. These were communicated through a 'Know your practice leads' handout to new staff. A programme of clinical audit was carried out, subjects selected from QOF outcomes, from the CCG, following an incident or from the GP's own reflection of practice. The practice wished to develop a more strategic audit programme, and had also recently joined a Primary Care Research Forum, which gave the opportunity to participate in various studies. The practice had arrangements for identifying, recording and managing risks.

Practice seeks and acts on feedback from users, public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. There was an engaged and enthusiastic Patient Participation Group (PPG), which met every two months at the practice premises.

The practice had discussed the previous 12 months friends and family survey results with the PPG, and actions arising from this. Results were analysed monthly, either in conjunction with the PPG or through practice meetings. Actions included a need to upgrade the phone system, and additional training for receptionists in dealing with difficult patients. Completed actions included a change to the telephone automated welcome message.

Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.