

Magnolia House

Quality Report

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Date of inspection visit: 8 November 2017
Date of publication: 14/12/2017

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

This practice is rated as Good overall. (Previous inspection October 2014 – Good)

The key questions are rated as:

Are services safe? – Requires Improvement

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Good

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

Older People – Good

People with long-term conditions – Good

Families, children and young people – Good

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

People whose circumstances may make them vulnerable – Good

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

We carried out an announced comprehensive inspection at Magnolia House on 8 November 2017. This inspection was carried out as part of our new phase of inspections, which commenced on 1 November 2017. The practice had previously been inspected in October 2014 and was rated as good overall and requires improvement for safe.

Our key findings were:

- The practice had systems in place to manage risk. However, these were not always consistently applied and we found concerns with patient group directions and patient specific directions, patient safety alerts processes and staff recruitment files.
- When incidents did happen, the practice learned from them and improved their processes.
- The practice routinely reviewed the effectiveness and appropriateness of the care it provided. It ensured that care and treatment was delivered according to evidence-based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it.
- There was a strong focus on continuous learning and improvement at all levels of the organisation.

The areas where the provider **must** make improvements are:

Summary of findings

- Ensure care and treatment is provided in a safe way to patients.

The areas where the provider **should** make improvements are:

- Ensure staff health needs are identified, reviewed and recorded so reasonable adjustments can be made, where necessary.

- Consider patient communication needs in regard to the accessible information standard.

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

Summary of findings

The six population groups and what we found

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

Older people	Good	
People with long term conditions	Good	
Families, children and young people	Good	
Working age people (including those recently retired and students)	Good	
People whose circumstances may make them vulnerable	Good	
People experiencing poor mental health (including people with dementia)	Good	

Magnolia House

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP specialist adviser and two further CQC inspectors in a shadowing role.

Background to Magnolia House

Magnolia House was established in 1911 and moved to its current premises in 1963. The practice serves Sunningdale, Sunninghill, Windlesham and some areas of Ascot and Virginia Water. The practice is one of the practices in Bracknell and Ascot Clinical Commissioning Group (CCG) and provides general medical services to approximately 9,200 registered patients.

All services and regulated activities are provided from:

Magnolia House, Station Road, Ascot, Berkshire, SL5 0QJ

Online services can be accessed from the practice website:

www.magnoliahouse.nhs.uk

According to data from the Office for National Statistics, this part of Berkshire has high levels of affluence and low levels of deprivation. The practice population has a predominantly higher proportion of patients over 75 and under 14 years of age compared to national averages. In addition, there are fewer working age patients (45 to 60 years) and lower levels of unemployment compared to the national average.

The ethnic mix of patients is predominantly white with approximately 10% of registered patients belonging to black or minority ethnic groups.

Are services safe?

Our findings

We rated the practice as requires improvement for providing safe services.

Safety systems and processes

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

- The practice conducted safety risk assessments. We saw examples of safety policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. The practice had systems to safeguard children and vulnerable adults from abuse. Policies were regularly reviewed and were accessible to all staff. They outlined clearly who to go to for further guidance.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an ongoing basis. Disclosure and Barring Service (DBS) checks were undertaken where required. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However, they did not retain records of staff health assessments to review if there were any reasonable adjustments that were required to support staff in their roles. The practice told us they asked about health needs at interview but could not show us an interview summary for any of the six staff files we reviewed.
- All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns. Staff who acted as chaperones were trained for the role and had received a DBS check.
- There was an effective system to manage infection prevention and control.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions. There were systems for safely managing healthcare waste.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed.
- There was an effective induction system for temporary staff tailored to their role.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections, for example, sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

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

- The systems for managing medicines, including vaccines, medical gases, and emergency medicines and equipment minimised risks. The practice kept prescription stationery securely and monitored its use.
- We saw evidence that not all staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. For example, we found the patient specific directions (PSDs) and patient group directions (PGDs) were being administered to patients without appropriate authorisation being obtained from a prescriber. The practice reviewed these after the inspection and provided evidence they had corrected the processes for

Are services safe?

nurses and the Healthcare Assistant to follow. (Patient Group Directions are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment. Patient Specific Directions are written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis).

- The practice had audited antimicrobial prescribing. There was evidence of actions taken to support good antimicrobial stewardship.
- Patients' health was monitored to ensure medicines were being used safely and followed up on appropriately. The practice involved patients in regular reviews of their medicines.

Track record on safety

The practice had a good safety record.

- There were comprehensive risk assessments in relation to safety issues for the majority of the premises and working practices. However, a treatment room on the ground floor had previously been identified as a risk. The practice had undertaken a risk assessment and corrected the previously identified issues. The risk assessment had not considered the clinical risk of having a potentially unwell patient being treated in the room where there was limited access and nowhere for the patient to be made comfortable in a medical emergency. Following the inspection, the practice decided to limit the use of the room to patient reviews and not to undertake any clinical procedures, such as phlebotomy or administering injectable medicines in the room.
- The practice monitored and reviewed activity. This helped it to understand risks and gave a clear, accurate and current picture that led to safety improvements.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. For example, a patient had requested a copy of their medical history and had collected this from the practice. They returned the notes when they found they contained information for another patient. The practice apologised and immediately contacted the patient whose notes had been given out in error. Reception staff were reminded to double check the names when handing out patient information.
- Not all alerts from the medicines and healthcare regulatory agency (MHRA) had been identified or logged for action by a clinician. The practice manager was the designated person who received the alerts and disseminated them to the GPs for review. There was no deputy to carry out this role if the practice manager was on leave which increased the risk of alerts being missed or not actioned within an appropriate timescale. Once this had been identified to the practice, they took immediate action to ensure all patient safety and medicines alerts had been identified, reviewed and logged. Two designated GPs were given the responsibility of checking the alerts log regularly to ensure no other alerts had been missed.

Are services effective?

(for example, treatment is effective)

Our findings

We rated the practice as good for providing effective services overall and across all population groups

Effective needs assessment, care and treatment

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

- Patients' needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- Data from 2015/16 showed the practice had low prescribing rates for antibacterial prescription items prescribed per Specific Therapeutic group compared with local and national averages.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice had identified how technology could improve patient outcomes and had reviewed options available to them. For example, they had purchased a technologically advanced watch that could read accurate blood pressure measurements over a 24 hour period. This replaced an arm cuff that inflates at set intervals which patients reported was more disturbing to their daily activities.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

Older people:

- The practice provided GP services to two large nursing and residential homes. Each home had a designated GP who undertook weekly visits to review patients with non-urgent health problems. This offered continuity of care and enabled GPs to reduce the number of emergency admissions. All residents were offered annual flu vaccines.
- Older patients identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.

- The practice followed up on older patients discharged from hospital. It ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- Data for 2016/17 showed the practice was not an outlier for any long term conditions and was achieving patient care in line with local and national averages. For example, overall performance for diabetes related indicators showed the practice had achieved 100% in 2016/17 compared to the clinical commissioning group average of 95% and national average of 91%.

Families, children and young people:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were below the target percentage of 90% for three of the four sub-indicators for children aged up to two years. The practice was aware of the poor uptake and had continued to engage with parents or carers to increase knowledge of the importance of having their child vaccinated.
- The practice looked after young patients from three local boarding schools.
- Two GPs had been trained to fit intrauterine devices and contraceptive implants and the practice offered a wide range of sexual health services, including screening for sexually transmitted infections. Young patients who were reluctant to be seen at the practice were signposted to external health services.

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

- The practice's uptake for cervical screening was 82%, which was in line with the 80% coverage target for the national screening programme.

Are services effective?

(for example, treatment is effective)

- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

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

- 83% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the previous 12 months. This was comparable to the clinical commissioning group (CCG) average of 83% and national average of 84%. The practice engaged with the local psychogeriatric team to improve outcomes for patients with dementia.
- 97% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. This was comparable to the CCG average of 92% and national average of 90%. Patients could receive depot neuroleptic injections on site. (Depot neuroleptics are a type of injectable medicine used to treat schizophrenic illness and other psychoses).
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, the percentage of patients experiencing poor mental health who had received discussion and advice about alcohol consumption (practice 97%; CCG average 92%; national average 91%); and the percentage of patients experiencing poor mental health who had received a blood pressure check in the preceding 12 months (practice 95%; CCG average 90%; national average 90%).

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. For example, an audit of patients with type two diabetes and renal impairment demonstrated quality improvement. A

search of patients was undertaken in October 2016 and identified 39 patients who fell into this category. Of these, 32 (82%) were receiving an appropriate dose of their medication and 15 had a record of a renal blood test in the preceding 12 months. The GPs held a clinical meeting to discuss the findings and designated two GPs to undertake reviews and recalls of these patients. When the audit was repeated in November 2017 the number of identified patients had increased to 67 with 100% being on the appropriate dose of medication. All 67 had a record of a blood test to check their renal levels.

Where appropriate, clinicians took part in local and national improvement initiatives. The practice had commenced the “Year of Care” model for diabetes in July 2016 and had surveyed patients to determine if they were satisfied with the new approach to diabetes care.

The most recent published Quality Outcome Framework (QOF) results were 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 96%. The overall exception reporting rate was 11% compared with the national average of 10%. (QOF is a system intended to improve the quality of general practice and reward good practice. Exception reporting is the removal of patients from QOF calculations where, for example, the patients decline or do not respond to invitations to attend a review of their condition or when a medicine is not appropriate.)

- Overall exceptions for diabetes indicators was 17% which was above the CCG average of 12% and national average of 13%. The GP specialist advisor with the inspection team reviewed a sample of patient records and found exceptions had been made on clinical grounds and were appropriate to the care of those patients.

Effective staffing

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

- The practice understood the learning needs of staff and provided protected time and training to meet them. Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop.

Are services effective?

(for example, treatment is effective)

- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, coaching and mentoring, clinical supervision and support for revalidation. Appraisals had not been continued in recent months due to a change in practice management in January 2017. The new practice manager was due to undertake appraisal training (to enable them to carry out effective appraisals) in November 2017 and we saw evidence that all staff had been allocated time for their appraisals over the next three months
- The practice ensured the competence of staff employed in advanced roles by audit of their clinical decision making, including non-medical prescribing.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.

Coordinating care and treatment

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

- We saw records that showed that all appropriate staff, including those in different teams, services and organisations, were involved in assessing, planning and delivering care and treatment.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.

- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

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

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns and tackling obesity.

Consent to care and treatment

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

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

Are services caring?

Our findings

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

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- All of the 19 patient Care Quality Commission comment cards we received were positive about the service experienced. This was in line with the results of the NHS Friends and Family Test and other feedback received by the practice.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The survey sent out 254 forms and 117 were returned. This represented about 1% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 87% and the national average of 89%.
- 88% of patients who responded said the GP gave them enough time; CCG average - 84%; national average - 86%.
- 95% of patients who responded said they had confidence and trust in the last GP they saw; CCG average - 94%; national average - 96%.
- 83% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG average - 82%; national average - 86%.
- 91% of patients who responded said the nurse was good at listening to them; CCG average - 90%; national average - 91%.
- 91% of patients who responded said the nurse gave them enough time; CCG average - 92%; national average - 92%.

- 98% of patients who responded said they had confidence and trust in the last nurse they saw; CCG average - 97%; national average - 97%.
- 92% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG average - 91%; national average - 91%.
- 94% of patients who responded said they found the receptionists at the practice helpful; CCG average - 86%; national average - 87%.

The practice had reviewed the satisfaction scores and distributed the results to staff at the practice.

Involvement in decisions about care and treatment

Staff helped patients be involved in decisions about their care but few members of staff were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given).

- Interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Staff facilitated patients involvement in decisions about their care. Leaders were not fully aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information they are given) but there were arrangements to meet the broad range of communication needs within the patient population. For example, the practice had identified they had a high number of hearing impaired patients registered with the practice (8%) and had decided to invest in a portable hearing loop. Reception staff told us they would offer a private room for hearing impaired patients if they required help and support as an interim measure.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.

The practice proactively identified patients who were carers. Carers were identified at registration and through information leaflets and posters in the waiting room. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 102 patients as carers (1% of the practice list).

Are services caring?

- The practice offered carers an annual flu vaccine and signposted them to services and organisations that could support them. The practice did not have a carers' champion and had begun assessing members of staff who may be suitable for the role. They had recently received training from the local Healthwatch on how to support carers.
- Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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:

- 88% of patients who responded said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 85% and the national average of 86%.
- 85% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG average - 78%; national average - 82%.
- 86% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG average - 87%; national average - 90%.
- 77% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG average - 82%; national average - 85%.

Privacy and dignity

The practice respected and promoted patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- The practice complied with the Data Protection Act 1998.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice had considered the needs of its population and tailored services in response to those needs. Extended hours were offered one evening per week and three Saturdays per month. Patients had access to online services such as booking appointments and requesting repeat prescriptions.
- The practice had recently begun considering accessible information standard and one GP had undertaken training which they had discussed with the team.
- The practice improved services where possible in response to unmet needs.
- The facilities and premises were appropriate for the services delivered. Patients and staff told us the building was old and required updating, but it did not affect patient care or treatment.
- The practice made reasonable adjustments when patients found it hard to access services. Whilst there was no lift to take patients up to the first floor, the practice was aware of the needs of patients who could not access the first floor and provided consultation in one of the ground floor treatment rooms.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home, in a care/residential home or supported living scheme.
- We spoke with two nursing homes who informed us the practice responded to the needs of their residents compassionately and in a timely way. They were able to access support and advice easily and the weekly GP visits offered continuity of care.

- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GPs also accommodated home visits for those who had difficulties getting to the practice.

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local multi-disciplinary teams to discuss and manage the needs of patients with complex medical issues.

Families, children and young people:

- We found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.

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

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers, those with a learning disability and war veterans.
- The new patient registration form included questions about caring responsibility and sensory impairment, to inform the practice of any additional care or support needs.

Are services responsive to people's needs?

(for example, to feedback?)

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia. Staff were undertaking additional training and were working towards becoming a dementia friendly practice.
- The practice held GP led dedicated monthly mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- Patients could access counselling services through the Berkshire wide talking therapies service. Details of this were available to patients in the patient leaflet and in reception.

Timely access to the service

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- The appointment system was easy to use.
- We saw appointment availability with a GP for same day, next day and routine within two weeks. Appointments could be booked up to six weeks in advance.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was comparable to local and national averages. This was supported by observations on the day of inspection and completed comment cards. The survey sent out 254 forms and 117 were returned. This represented about 1% of the practice population.

- 74% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 78% and the national average of 80%.
- 87% of patients who responded said they could get through easily to the practice by phone; CCG average - 73%; national average - 71%.

- 84% of patients who responded said that the last time they wanted to speak to a GP or nurse they were able to get an appointment; CCG average - 76%; national average - 75%.
- 81% of patients who responded said their last appointment was convenient; CCG average - 81%; national average - 81%.
- 80% of patients who responded described their experience of making an appointment as good; CCG average - 71%; national average - 73%.
- 57% of patients who responded said they don't normally have to wait too long to be seen; CCG average - 56%; national average - 58%.

Listening and learning from concerns and complaints

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

- Information about how to make a complaint or raise concerns was available and it was easy to do. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. 18 complaints were received in the last year. We reviewed two complaints and found that they were satisfactorily handled in a timely way.
- The practice learned lessons from individual concerns and complaints and also from analysis of trends. It acted as a result to improve the quality of care. For example, a patient complained about being unable to access a convenient appointment due to their working hours. The practice signposted the patient to an extended hours service provided from another practice, which was available for patients to access. They also arranged further training for the reception staff so they were aware they could offer this service to other patients who could not access a convenient appointment at Magnolia House.
- The practice held twice yearly review meetings to analyse trends and themes from complaints and significant events. Changes had been made to make improvements, such as, the practice had decided to trial a duty GP triage appointment system and the practice had submitted a bid for a clinical pharmacist to join the team to undertake prescription reviews and support clinicians in medicines management.

Are services well-led?

Good 

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

Our findings

We rated the practice as good for providing a well-led service.

Leadership capacity and capability

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

- Leaders had the experience, capacity and skills to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice was aware the current premises was old and did not have capacity for expansion. They had applied for planning permission to build a new practice locally and were in discussion with other practices with regard to sharing the new building.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality care and promote good outcomes for patients.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- The practice developed its vision, values and strategy jointly with patients, staff and external partners. The GP partners had held an away day in June 2017 where the surgery goals were discussed and planned. They had reviewed staffing, resources and technology needs over the next five years. They had analysed their strengths and weaknesses, and determined future risks and opportunities covering a five year period.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them.
- The strategy was in line with health and social priorities across the region. The practice planned its services to meet the needs of the practice population.

- The practice monitored progress against delivery of the strategy.

Culture

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

- Staff stated they felt respected, supported and valued. They were proud to work in the practice.
- The practice focused on the needs of patients.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. For example, a patient's notes had been given to another patient in error. The practice contacted both patients and offered an apology. They reviewed their processes with the administration team to ensure checks were made on patient identifiable information in the future to prevent the situation occurring again.
- Staff we spoke with told us they were able to raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There were processes for providing all staff with the development they need. This included career development opportunity conversations. Although not all staff had received regular annual appraisals in the last year, the practice had a schedule of appraisals which were due to be completed by February 2018. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff.
- The practice actively promoted equality and diversity. It identified and addressed the causes of any workforce inequality. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

Are services well-led?

Good 

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

There were clear responsibilities, roles and systems of accountability to support good governance and management, with the exception of patient group directions and patient specific directions and arrangements for patient safety alerts.

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

Managing risks, issues and performance

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

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. However, the risk assessment for the ground floor phlebotomy room had not considered clinical risks. The practice reviewed this arrangement after the inspection and decided to only undertake long term condition reviews in the room within two days of the inspection.
- The practice had processes to manage current and future performance. Performance of employed clinical staff could be demonstrated through audit of their consultations, prescribing and referral decisions. Practice leaders had oversight of incidents and complaints.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality.
- The practice had plans in place and had trained staff for major incidents.
- The practice implemented service developments and where efficiency changes were made this was with input from clinicians to understand their impact on the quality of care.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

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

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. We spoke with two nursing homes whose residents were looked after by the practice. They told us they had a good working relationship with the GPs and felt they were listened to. Suggestions and feedback were taken and acted upon by the practice.
- There was an active patient participation group (PPG). We spoke with one member of the PPG who told us they had undertaken patient surveys and fed back patient views to the practice. They had been involved in the planning application for the new practice building.
- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

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

Are services well-led?

Good 

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

- There was a focus on continuous learning and improvement at all levels within the practice. The practice was part of a federation with other practices locally and had participated in innovations to improve patient care. For example, a one stop atrial fibrillation screening service used a new device to record heart rhythm patterns onto a mobile telephone.
- Staff knew about improvement methods and had the skills to use them. There were opportunities for staff to undertake training to improve skills and enhance patient care.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.

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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>Care and treatment must be provided in a safe way for service users</p> <p>How the regulation was not being met:</p> <p>The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular:</p> <ul style="list-style-type: none">• The provider had not reviewed and assessed all patient safety alerts received from the Medicines and Healthcare Regulatory Agency.• The risk assessment for the phlebotomy room had not considered clinical or emergency risks to patients.• Patient group directions and patient specific directions had not been administered in line with legislation. <p>This was in breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p>