

Marple Bridge Surgery

Quality Report

Marple Bridge Surgery
Town Street
Marple Bridge
Stockport
Greater Manchester
SK6 5AA

Tel: 01614272049

Website: WWW.MarpleBridgeSurgery.nhs.uk

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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?

Requires improvement



Key findings

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Letter from the Chief Inspector of General Practice

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

The key questions are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Good

Are services responsive? – Good

Are services well-led? – Requires Improvement

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 Marple Bridge Surgery on 27 March 2018. This inspection was carried out under Section 60 of the Health and Social Care Act 2008 as part of our regulatory

functions. The inspection was planned to check whether the provider was 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.

At this inspection we found:

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had systems to minimise risks to patient safety. When incidents did happen, the practice learned from them and improved their processes. However, improvements were required. These included implementing a system to record action taken by the practice in response to safety alerts; maintaining and recording a comprehensive overview of staff training undertaken with dates; ensuring policies, procedures, recruitment records and patient group directives were up to date and reflected current legislation.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.

Summary of findings

- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints, concerns and suggestions.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.

The area where the provider **must** make improvements as they are in breach of regulations is:

- Establish effective systems and processes to ensure good governance in accordance with the fundamental standards of care.

The areas where the provider should make improvement are:

- Consider providing additional training in coding patient notes.
- Consider review significant/critical events on an annual basis.

Professor Steve Field (CBE FRCP FFPH FRCGP)

Chief Inspector of General Practice

Marple Bridge Surgery

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 an additional CQC inspector.

Background to Marple Bridge Surgery

Marple Bridge Surgery Town Street, Marple Bridge, Stockport, SK6 5AA is based in Marple Bridge village Stockport in a converted church building. It is part of the NHS Stockport Clinical Commissioning Group (CCG.) Services are provided under a general medical service (GMS) contract with NHS England. The practice is situated on a busy road with no on street parking but pay and display facilities available directly across the road and free parking is available nearby. The practice has 6476 registered patients.

Information published by Public Health England, rates the level of deprivation within the practice population groups as ten on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest. Deprivation affecting children within the practice is rated at 4.9% compared with CCG average of 16.2%. Deprivation affecting older people is rated at 7.4% compared with CCG

average of 17.7%. These results are well below the national averages of 19.9% for children and above for older people at 20.4% nationally. The practice population includes a comparable proportion (17.9%) of people under 18 years of age, and a higher proportion (25.6%) of people over the age of 65 years, in comparison with the national average of 20.8% and 17.2% respectively. The practice has 48% of its population with a long-standing health condition, which is lower than the CCG average of 55% and the England average of 54%. Unemployment at 1.4% is lower than the CCG average of 3.1% and England average of 5%.

The practice is a partnership GP practice with four partners (male and female) two salaried GPs and a trainee GP. The practice is supported by three practice nurses and two health care assistants and an administration team lead by the practice manager and her deputy. The practice is a training practice for GPs during their training with an identified training lead GP.

The practice opens from 7.20am to 6.30pm (surgery appointments until 6pm) Monday to Friday and does not close for lunch. Patients requiring a GP outside of normal working hours are advised to contact 111 who will refer them into the out of hours provider Mastercall if required. After the practice is closed an answering machine informs patients of this process.

The practice provides level access to the building and is adapted to assist people with mobility problems; the practice provides a wheelchair to assist patients with mobility issues.

Are services safe?

Our findings

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

Safety systems and processes

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

- The practice had a suite of safety policies including adult and child safeguarding policies which were regularly reviewed and communicated to staff. Staff received safety information for the practice as part of their induction and refresher training. Policies were regularly reviewed and were accessible to all staff, including locums. They outlined clearly who to go to for further guidance.
- There was a system to highlight vulnerable patients on records and a risk register of vulnerable patients.
- The practice worked with other agencies to support patients and protect them from neglect and abuse. Staff took steps to protect patients from abuse, neglect, harassment, discrimination and breaches of their dignity and respect.
- All staff received up-to-date safeguarding and safety training appropriate to their role. Staff knew how to identify and report concerns. Reports and learning from safeguarding incidents were available to staff. Staff who acted as chaperones were trained for the role and had received a DBS check.
- The practice carried out staff checks, including checks of professional registration where relevant, on recruitment and on an 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). The system for storing recruitment information could be improved, for example copies of proof of identity of new staff and notes from interviews had not been retained. Some recruitment files were lacking assurances that staff were physically and mentally fit to perform their role. Shortly after our inspection we were sent new protocols by the provider indicating new systems were being introduced.
- There was an effective system to manage infection prevention and control.

- There were systems for safely managing healthcare waste.
- The practice ensured that facilities and equipment were safe and that equipment was maintained according to manufacturers' instructions.

Risks to patients

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

- There were arrangements for planning and monitoring the number and mix of staff needed. There was an effective approach to managing staff absences and for responding to epidemics, sickness, holidays and busy periods.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- We noted that the door providing access to the private area in reception where staff worked and records were kept was not routinely locked. Management told us that this would be addressed.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.

Information to deliver safe care and treatment

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

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

Safe and appropriate use of medicines

Are services safe?

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

- The systems for managing and storing medicines, including vaccines and emergency medicines and equipment minimised risks. The practice had carried out an appropriate risk assessment to identify medicines that it should stock. The practice kept prescription stationery securely and monitored its use. We noted that some uncollected repeat prescriptions had not been reviewed in a timely manner, the lead GP told us that this would be addressed as soon as practicable.
- Staff prescribed, administered or supplied medicines to patients and gave advice on medicines in line with legal requirements and current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The practice prescribing policy was in need of review.
- 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.
- Prescribing data for the practice showed that data for the prescribing of antibacterial prescription items showed that practice prescribing was similar at 1.07 to local level of 1.04, both of which were slightly higher than the national level of 0.98.
- Data for the percentage of antibiotic items such as Co-Amoxiclav, Cephalosporins or Quinolones for the period 01 July 2016 to 30 June 2017 showed the practice's rate of prescribing at 5.6% compared to the local average of 5.5% but was significantly lower than the national average of 8.9%. (Co-Amoxiclav, Cephalosporins or Quinolones are broad-spectrum antibiotics that can be used when others have failed. It is important that they be used sparingly, to avoid drug-resistant bacteria developing).
- Patient Group Directives (PGDs) were in place but required signing by the nurses and the appropriate authority. (Patient Group Directions provide a legal framework that allows some registered health professionals such as nurses to supply and/or administer specified medicines to a pre-defined group of patients for example the administration of a vaccination). We were assured this would be completed as soon as possible.

Track record on safety

The practice had a good safety record.

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

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- There was a system and policy for recording and acting on significant events and incidents. Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There were adequate systems for reviewing and investigating when things went wrong. The practice learned and shared lessons, identified themes and took action to improve safety in the practice. Monthly significant event analysis (SEA) meetings took place, although the review of these was difficult as they were recorded on a single document with no analytical functionality. We noted that following a data breach, a SEA was raised and investigated, as a result apologies were offered and accepted by the two patients affected and systems were changed to prevent a reoccurrence. Regular reviews of all new cancers, deaths and serious health events took place to examine what, if anything could have been done differently. A review of critical events in December 2017 revealed six separate issues where errors in the coding of patient notes were present, there was no evidence of what had been introduced to reduce or eliminate these errors.
- There was a system for receiving and acting on safety alerts. The practice learned from external safety events as well as patient and medicine safety alerts. However the system was paper based and did not record what actual action was taken in response to these alerts. Shortly after our inspection we were sent new protocols by the provider indicating new systems were being introduced.
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Are services safe?

actual action was taken in response to these alerts. Shortly after our inspection we were sent new protocols by the provider indicating new systems were being introduced.

Are services effective?

(for example, treatment is effective)

Our findings

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

Please note: Any Quality and Outcomes Framework (QOF) data relates to 2016/17. 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.)

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.

The practice had a good understanding of the challenges they faced in meeting the needs of their local patient population.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- The practice utilised the expertise of the Clinical Commissioning Group (CCG) medicines optimisation team to ensure prescribing for patients was safe and effective. For example, prescribing data for the practice showed that the average daily quantity of Hypnotics prescribed per Specific Therapeutic group for the period 01 July 2016 to 30 June 2017 was lower than other local GP practices and lower than the national average. 0.58 as opposed to 1.02 and 0.9 respectively. (This data is used nationally to analyse practice prescribing and 'hypnotics' are drugs primarily used to induce sleep.)
- The practice undertook regular searches of patient records to monitor those patients prescribed medicines that required regular checks such as blood tests. Shared care protocols with secondary care service such as hospitals were in place to ensure patients received the right level of monitoring.
- We saw no evidence of discrimination when making care and treatment decisions.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.

The most recent published QOF results were 100% of the total number of points available compared with the CCG average of 98% and national average of 95%. The overall exception reporting rate was 3.9% compared with local average of 13% and the national average of 10%.

Older people:

This population group was rated good for effective because:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- Patients aged over 75 were invited for a health check. If necessary they were referred to other services such as voluntary services and supported by an appropriate care plan.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. The practice is currently reviewing its systems to identify patients who would benefit from referral to the "Steady in Stockport" initiative, which aims to help people who are at risk of falling.

People with long-term conditions:

This population group was rated good for effective because:

- 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. For example nurses had received training in diabetes and pre-diabetes management.
- The practice supported patients with skin issues and two of the GPs were trained in the use of a dermatoscope, referrals to secondary care had fallen by 8.35% in the last two years.
- The most recent available QOF data from 2016/17 showed the practice achieved higher results (85%) for blood measurements for diabetic patients (HbA1c of 64

Are services effective?

(for example, treatment is effective)

mmol/mol or less in the preceding 12 months). The local CCG average achievement was 82% and the national average was 80%. The practice had a lower percentage of patients who were excepted, 4% compared with the local average 10% and national average of 12%.

- QOF data available for other long-term conditions showed the practice's performance was higher when compared to local and national averages. For example: The percentage of patients with hypertension (high blood pressure) in whom the last blood pressure reading (measured in the preceding 12 months) was 150/90 mmHg or less was 93%, compared to the local average of 85% and the national average of 83%. Exception reporting at 0.8% was comparable with local averages of 2.6% and national average of 4%. The percentage of patients with COPD (Chronic Obstructive Pulmonary Disease) who had been reviewed in the preceding 12 months was 93%, which reflected the local average of 91% and national average of 90%. Exception reporting was lower at 4.4% (6.3% locally and 11% nationally)
- 79% of patients with asthma on the register had an asthma review in the preceding 12 months compared to the CCG average of 78% and the national average of 76%. Exception reporting was lower at 0% compared with 3% locally and 8% nationally.

Families, children and young people:

This population group was rated good for effective because:

- Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were in line with the target percentage of 90% or above for all four indicators.
- The practice had arrangements to identify and review the treatment of newly pregnant women on long-term medicines. These patients were provided with advice and post-natal support in accordance with best practice guidance.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation.
- A school nurse regularly attends multi-disciplinary meetings (MDTs) to review children at risk.

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

This population group was rated good for effective because:

- Current public health data showed the practice's uptake for cervical screening was 85.3%, which was higher than the local average of 76% and the national average of 72%.
- The practice referred its patients to attend national screening programmes for bowel and breast cancer. The practice patient uptake of these tests was above the CCG and national average. For example, data from 2016/17 showed that 74% of females aged between 50 and 70 years of age were screened for breast cancer in the last 36 months, which was higher than the CCG average of 69% and the England average of 70%. Data showed screening for bowel cancer within 6 months of invitation was high at the practice with a rate of 66% compared to 56% for the CCG and 54% for the England averages. The practice worked with the NHS bowel screening service to help trace and encourage patients who had not undertaken the bowel screening.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks, including NHS checks for patients aged 35-74 years.
- There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.
- Appointments were available for booking up to three months in advance as well as early morning and same day appointments.

People whose circumstances make them vulnerable:

This population group was rated good for effective because:

- 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 lead GP for palliative care monitored all patients on the palliative care register. Regular multidisciplinary team meetings were held to review patients identified at potential risk or vulnerable patients to ensure the appropriate treatment, care and support was made available or in place.

Are services effective?

(for example, treatment is effective)

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. Any patients who has learning disabilities and fails to attend an appointment is contacted to check on their welfare.
- Proactive working relationships were established with a range of community professionals to ensure patients care needs were supported. These included the mental health team, nurse practitioner, health visitors, midwives and Age UK.

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

This population group was rated good for effective because:

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. 86% 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 local average of 86% and national average of 84%. Exception reporting was 8.6% compared to 5.1% (local) and 6.8% (national). Patients with dementia had their care plans reviewed every six months. 96% of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the previous 12 months. The local average was 93% and national average 90%. Exception reporting was 0%, 8.2% and 12.5% respectively.
- The practice specifically considered the physical health needs of patients with poor mental health and those living with dementia. For example, 96% of patients experiencing poor mental health had received discussion and advice about alcohol consumption. This is comparable to the local average of 92% and national average of 91%. Exception reporting at the practice was 0% and lower than local and national averages. The practice was performing well in relation to its QOF and its exception rates which reflected well against local and national averages

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 a recent audit was undertaken into patients with hypothyroidism and its treatment; this led to a reduction in the necessity for blood tests. Where appropriate, clinicians took part in local and national improvement initiatives. For example a review of safeguarding training identified the need for clinical staff to undertake “Prevent” training.

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. Staff were encouraged and given opportunities to develop. There was no system or documented overview of staff training and it was left to individual staff members to alert the management team of requirements for some refresher training. The practice manager told us that a system to oversee and better plan training would be introduced.
- The deputy practice manager had introduced alternative and more interactive methods to deliver staff training, for example quizzes, where results were analysed and additional training provided where appropriate.
- The practice provided staff with ongoing support. This included an induction process, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and support for revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice was a GP training practice. The practice had supported trainee GPs in their training over many years. One trainee GP had been supported to complete their training and was now employed by the practice.

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.

Are services effective?

(for example, treatment is effective)

- 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.
- We saw that the practice nurses had a scheduled 30 minute handover period, when no appointments were booked. This enabled them to communicate any relevant information and discuss current issues.

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. Patients on the practice palliative care register were discussed at regular multi-disciplinary case review meetings.

- Staff encouraged and supported patients to be involved in monitoring and managing their health.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.

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. For example to Mental Capacity Act.
- 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 asked new patients whether they had veteran status and recorded this on the patient notes so that they could be managed proactively as required.
- 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 but two of the 62 patient Care Quality Commission comment cards we received were positive about the service experienced. This is in line with the results of the NHS Friends and Family Test and other feedback received by the practice. There were two negative comments about getting through to the practice on the telephone.

Results from the July 2017 annual national GP patient survey showed patients felt they were treated with compassion, dignity and respect. 221 surveys were sent out and 130 were returned. This represented about 2% of the practice population. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 96.3% of patients who responded said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91.6% and the national average of 88.8%.
- 96.4% of patients who responded said they had confidence and trust in the last GP they saw; CCG – 97.1%; national average – 95.5%.
- 93.9% of patients who responded said the last GP they spoke to was good at treating them with care and concern; CCG – 88.5%; national average – 85.5%.
- 98.2% of patients who responded said the nurse was good at listening to them; (CCG) – 94%; national average – 91.4%.

- 98.5% of patients who responded said the last nurse they spoke to was good at treating them with care and concern; CCG – 94.1%; national average – 90.7%.

Involvement in decisions about care and treatment

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

- Interpretation services were available for patients who did not have English as a first language.
- Staff communicated with patients in a way that they could understand, for example, communication aids and easy read materials were available. There was a portable hearing loop for patients who had difficulty hearing. There were also alerts on the practice's computer systems so staff were made aware of any particular needs of a patient.
- 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. This was achieved by speaking with patients opportunistically and then recording the fact on the practice computer system. The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 99 patients as carers (1.5% of the practice list). Carers were offered health checks and staff offered advice about where extra help and support was available.

Staff told us that if families had experienced bereavement, their usual GP contacted them to offer help and support. 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 above the local and national averages:

- 93.3% 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 89.4% and the national average of 86.4%.

Are services caring?

- 91.7% of patients who responded said the last GP they saw was good at involving them in decisions about their care; CCG - 86%; national average - 82%.
- 100% of patients who responded said the last nurse they saw was good at explaining tests and treatments; CCG - 92.9%; national average - 89.9%.
- 93.8% of patients who responded said the last nurse they saw was good at involving them in decisions about their care; CCG - 88.6%; national average - 85.4%.

Between January 2015 and March 2018 the practice had collected 1,101 Friends and Family responses, analysis of these responses revealed that in relation to recommending the practice, 95.6% would be extremely likely, 2.2% Likely, 0.2% neither, 0.9% unlikely and 1% very unlikely.

The practice scored consistently at a very high level on its satisfaction surveys.

Privacy and dignity

The practice respected patients' privacy and dignity.

- Staff recognised the importance of patients' dignity and respect.
- Conversations with receptionists could not be overheard by patients in the waiting room.
- All patients' records, both paper and electronic were stored securely. Staff had received training in confidentiality and data protection.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

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

Responding to and meeting people's needs

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

- The practice understood the needs of its population and tailored services in response to those needs. (For example extended opening hours, online services such as repeat prescription requests, advanced booking of appointments and advice services for common ailments.)
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. For example, a wheelchair was available for people with mobility problems and some health information was printed in easy read format.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- The practice had recently introduced a text messaging system to remind patients of forthcoming appointments, vaccinations and reviews of long term conditions. The system also allowed patients to cancel appointments; this had led to a reduction in failures to attend appointments from around 130 per month to 90 per month.

Older people:

This population group was rated good for responsive because:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.

People with long-term conditions:

This population group was rated good for responsive because:

- The practice maintained up to date registers of patients with long term or chronic health conditions.
- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. The registers detailed the date of the last review. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice undertook opportunistic monitoring of patients who attended the practice.
- This offered lifestyle support and guidance and referred to healthcare education programmes.
- The practice maintained regular contact with a range of community health and social care professionals to ensure patients received the right care and support.

Families, children and young people:

This population group was rated good for responsive because:

- 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 were offered a same day appointment when necessary.
- The practice worked closely with the community midwife service, health visitors and school nurses.

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

This population group was rated good for responsive because:

- 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 Monday to Friday and over lunchtimes.
- Telephone consultations were available which supported patients who were unable to attend the practice during normal working hours.

People whose circumstances make them vulnerable:

This population group was rated good for responsive because:

Are services responsive to people's needs?

(for example, to feedback?)

- The practice held a register of patients living in vulnerable circumstances including homeless people, and those with a learning disability.
- Patients with complex needs were offered longer appointments.
- There were regular meetings with other health and social care professionals to discuss the care and treatment of vulnerable patients.

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

This population group was rated good for responsive because:

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice worked closely with mental health services and dependency services to better support their patients.
- The practice proactively signposted patients to support organisations for those with mental health needs and those who had recently suffered bereavement.
- Patients with symptoms of memory loss were referred appropriately for assessment.

Timely access to care and treatment

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

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised. Requests for urgent appointments were always accommodated.
- Patients reported that the appointment system was easy to use.
- The practice had introduced the use of wound glue which could be used to treat minor cuts which otherwise might require hospital attendance for stitches.

Results from the July 2017 annual national GP patient survey showed that patients' satisfaction with how they could access care and treatment was higher than local and national averages. This was supported by observations on the day of inspection and completed comment cards.

- 92% of patients who responded were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 82% and the national average of 80%.
- 95% of patients who responded said they could get through easily to the practice by phone; CCG - 76%; national average - 71%.
- 97% 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 - 79%; national average - 76%.
- 97% of patients who responded said their last appointment was convenient; CCG - 85%; national average - 81%.
- 97% of patients who responded described their experience of making an appointment as good; CCG - 78%; national average - 73%.
- 79% of patients who responded said they don't normally have to wait too long to be seen; CCG - 60%; 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 on how to make a complaint was clearly displayed in the waiting area and the practice had a complaints policy.
- The complaint policy was dated and required review as it referred to the Primary Care Trust (PCT), which was replaced by the CCG in 2013.
- There were three complaints recorded in 2017, we reviewed these and saw that they had been recorded, responded to, investigated and finalised in an effective and timely manner. Apologies were offered where appropriate and the provider understood their responsibilities in relation to duty of candour.

The complaints file was well ordered and easy to read, complaints were discussed at weekly meetings. The practice manager confirmed there was no formal system in place yet to review complaints on an annual basis. They said they intended to undertake this in the near future, as this would provide data to identify themes, trends and learning.

Are services well-led?

Requires improvement 

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

Our findings

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

Leadership capacity and capability

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

- Leaders had the experience, capability and integrity to deliver the practice strategy and address risks to it.
- They were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them and were keen to address any identified issues for improvement.
- 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 made use of an area adjacent to reception to meet and discuss issues. It was a place where all staff could engage and communicate at all levels. Staff we spoke with told us it was effective in keeping open and consultative communication.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice. The practice had used its status as a training practice to employ new clinical staff.

Vision and strategy

The practice had an understanding of their vision and credible strategy to deliver high quality, sustainable care.

- There was a clear understanding of a vision and set of values, although this was not documented. The practice had a realistic strategy and supporting business plans to achieve priorities. Aspirations for achievement were discussed amongst all staff at team meetings and bi-annual “away days”.
- The practice developed its aims and strategy jointly with patients, staff and external partners; this was articulated in its patient information leaflet and statement of purpose.
- Staff were aware of and understood the practice’s aims 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.

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 were prepared to act on behaviour and performance inconsistent with their 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, we saw examples of this.
- 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 appraisal and career development conversations. All staff had received an annual appraisal in the last year. Staff were supported to meet the requirements of professional revalidation where necessary.
- Clinical staff, including nurses, were considered valued members of the practice team. They were given protected time for professional development and evaluation of their clinical work.
- There was a strong emphasis on the safety and well-being of all staff. Staff we spoke with told us they felt supported and included. We were told the practice team felt like a family.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff members.

Governance arrangements

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

- Structures, processes and systems to support good governance and management were established. We noted some areas required further development, for

Are services well-led?

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example planning and recording of staff training, management of safety alerts, the maintenance of recruitment records and some aspects of medicine management such as the signing of patient group directives. 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, although some staff we spoke with were unsure if they had received infection control training. We were unable to verify the details of all staff training as records kept were lacking detail. We saw that the practice had an organisational chart detailing all staff members and the structure of the team. We discussed with managers the potential for that to be extended to include the lead roles of each GP and any lead roles of other staff members, for example infection control.
- Practice leaders had established proper policies, procedures and activities to ensure safety and assured themselves that they were operating as intended. Some policies were in need of review for example the complaints procedure.
- Some systems and governance checks were not effective in ensuring essential standards were maintained.

Managing risks, issues and performance

There were clear and effective clarity around 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. We discussed with managers ways of improving the ability to audit and review data collected.
- The practice had processes to manage current and future performance. There was evidence practice leaders responded to national and local safety alerts, incidents, and complaints, there was little evidence of regular review of these issues.
- 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. There was a clear and comprehensive business continuity plan.
- 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 following patient surveys and feedback through the patient participation group (PPG).
- 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.
- There was an active patient participation group. We spoke with one of the members of the group, we were told that the practice leaders were effective and engaging and that there were plans to form a joint group with other nearby practices.

Are services well-led?

Requires improvement 

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

- The service was transparent, collaborative and open with stakeholders about performance.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement at all levels within the practice. For example reviews of significant events led to improvements in the way care was delivered.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal reviews of incidents and complaints. Learning was shared at team meetings and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance; we discussed with managers how these could be more effective if linked to a practice vision.

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 17 HSCA (RA) Regulations 2014 Good governance</p> <p>Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.: Good Governance</p> <p>Systems or processes must be established and operated effectively to ensure compliance with the requirements of the fundamental standards as set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>How the regulation was not being met:</p> <p>The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular:</p> <ul style="list-style-type: none">• Recruitment procedures did not include evidence of all the requirements of Schedule 3 of the Health and Social Care Act• Systems to overview and manage staff training were not in place.• Medicine management systems were not effectively established in that patient group directives were not signed and a system to monitor the collection of prescriptions by patients was not established.• There was no effective system for recording action taken on receipt of safety alerts• A system to ensure policies and procedures were up to date and reflected relevant legislation and guidance was not effective. |