Twin Oaks Medical Centre

Quality Report

Ringwood Road
Bransgore
Christchurch
Dorset
BH23 8AD
Tel: 01425 672741
Website: www.twinoaksmedicalcentre.co.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?	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was a comprehensive inspection of the Twin Oaks Medical Centre which was carried out on 4 November 2014.

We rated this practice as good overall. The practice was well led by the GP partners and the practice manager who provided a caring, compassionate service. GPs and practice staff demonstrated good communication and involvement with the local community.

Our key findings were as follows:

- The practice was rated highly by patients for the respect they were shown, their confidence in the ability of the doctor or nurse and their ability to listen.
- The practice provided GP appointments at times that met the needs of their patients with same day appointments or telephone consultations. Some appointments were available from 7.30am and some available until 7.30pm for patients who could not attend during working hours.
- The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.
- The practice worked closely with midwives and health visitors who used the practice premises to meet with their patients.

We saw areas of outstanding practice including:

- The practice had developed a health and education initiative with a local school to identify the needs of children and to improve their health and education outcomes.
- GPs at the practice gave their personal mobile telephone numbers to patients at the end of life so they could continue to provide care out of hours for their patient.

Summary of findings

- The practice was aware of the health, social and cultural beliefs of a nearby housed gypsy and traveller community. They had a flexible approach to appointments to ensure GPs made themselves available to see these patients if they attended outside their appointment time.

However, there were also areas of practice where the provider needs to make improvements.

Importantly, the provider must:

- Have a risk assessment and policy for the management and testing of Legionella.
- Carry out a risk assessment around the disposal of any clinical waste generated in consultation rooms.
- Carry out a full audit of the practice in relation to infection prevention and control.
- Provide the lead member of staff for infection control with appropriate training for their role.

In addition the provider should:

- Ensure the access needs of patients with disabilities are met including access to a toilet.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Staff had received up to date training in safeguarding and were focused on early identification and referral to local safeguarding teams.

Arrangements were in place to deal with emergencies and major incidents. Staff were trained and there was appropriate equipment and medicines available to deal with a medical emergency. A detailed business continuity plan was in place to deal with any event which may cause disruption to the service. There were enough staff to keep people safe.

We found a clean and well maintained building. However improvements were needed to the systems and processes in relation to infection control. The practice had audited infection control procedures in 2012 and had completed an annual review between July and October 2014. The practice had not risk assessed the need for the safe disposal of waste. The lead member of staff for infection control had not received training for the role.

Are services effective?

Good

The practice is rated as good for effective. Our findings at inspection showed the practice delivered care and treatment in line with recognised best practice. They worked with other health professionals to ensure a complete service with the right treatment outcomes for their patients. The provider had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Clinical audit cycles had been completed, which had resulted in improvements to patient care and treatment.

Patients were supported to manage their own health and were treated by appropriately trained staff. In most cases staff received the necessary support, training and development for their role and extended duties.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Satisfaction scores on consultations with doctors and nurses showed that 97% of practice respondents said their GP was good or very good at listening to them and 97% said the GP gave them enough time. Feedback from patients about their

Summary of findings

care and treatment was consistently and strongly positive. Data from the national GP survey showed the practice scored highly in caring related questions for example 93% of respondents said the last GP they saw or spoke to was either good or very good at treating them with care and concern.

We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on.

There were strong links with the community and support organisations. Practice staff were aware of individual patient needs through their local knowledge and provided personal support such as delivering prescriptions to patient's homes if patients are unable to arrange collection. They also supported a local housed gypsy and traveller community by communicating between them and the hospital when necessary.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the clinical commissioning group to secure service improvements where these were identified such as the provision of a midwife from a local hospital. We found the practice had initiated many positive service improvements for their patient population that were over and above their contractual obligations, particularly for people in vulnerable circumstances and those who found access the practice difficult in the rural area.

Patients reported good access to the practice and a GP of choice, with continuity of care. Urgent appointments were available the same day. Clear details of the appointment system were available in the practice leaflet and on the practice website.

The few complaints received were managed swiftly and openly as part of the system of patient feedback.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and systems in place to monitor and improve quality and identify risk. The

Summary of findings

practice proactively sought feedback from patients, which it acted on. The practice had an active patient participation group. Staff had received regular performance reviews and attended staff meetings and events.	

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice was rated good for the care of older people. Each patient over 75 years of age had a named GP, but were able to see any GP of their choice for continuity of care when necessary or specialised care and treatment if needed. We saw that the practice responded to the needs of this population group by improving access to the services they needed.

The practice had a number of older patients who lived in care homes. If these patients required a GP they were visited in their home. There were good links with local community groups who were able to provide transport for patients to the practice or to hospital. The practice hosted a support group at the practice each month to support and advise their older patients.

The practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Administration staff were responsible for tracking certain streams of information such as asthma and diabetes and inviting patients into the practice for health checks.

Families, children and young people

Good

The practice was rated good for the care of families, children and young people. The practice had a GP partner with an interest in family planning and provided shared ante natal care with the practice midwife.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children.

The practice worked closely with midwives and health visitors who used the practice premises to meet with their patients. Health visitors attended the practice's clinical meetings every two months to share information and best practice and held a weekly clinic at the practice.

Summary of findings

The practice was able to offer minor injury treatment to patients and temporary patients as the practice area covered a number of local holiday campsites and an activity centre.

Working age people (including those recently retired and students)

Good

The practice was rated good for the care of working age people (including those recently retired and students). Early morning appointments, lunchtime and evening surgeries were available for patients. This increased the accessibility of their service to people who were unable to attend during the day due to work commitments. The practice nurse attended a local college to carry out a new patient clinic for recently enrolled students.

The practice had proactively promoted the use of on line appointment booking and on line ordering of prescriptions. There was capacity within the appointment system for all patients to be seen the same day or to have a telephone consultation.

People whose circumstances may make them vulnerable

Good

The practice was rated good for people living in vulnerable circumstances. The practice provided health checks for their patients who had a learning disability and lived in the community.

The practice provided healthcare for a housed gypsy and traveller community. All practice staff were aware of their health, social and cultural needs and had built a trusting, caring relationship. All staff were able to describe the systems they had in place to meet the needs of these patients. This included a flexible approach to appointments which ensured that GPs made themselves available to see these patients if they attended outside their appointment time and how they ensured the patients did not leave before seeing the GP or nurse.

The practice had developed a health and education initiative with a local school to improve outcomes for this group to address the barriers in place to their health and well-being.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. .

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

Summary of findings

The practice held twice monthly multi-disciplinary team meetings where community care teams and when necessary social workers discussed the case management of people experiencing poor mental health.

The practice ensured patients were able to speak with their GP when they needed to by telephone, or at times of crisis their GP would see them if they called into the practice.

The practice had sign-posted patients experiencing poor mental health to resources such as a counsellor from a local support group who worked at the surgery. The counsellor was able to see referrals from the GPs and patients were able to self-refer to use their service.

Summary of findings

What people who use the service say

We spoke with nine patients on the day of our inspection. We reviewed 15 comment cards which had been completed by patients in the two weeks leading up to our inspection.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions, people with a diagnosis of poor mental health and people aged over 75 years of age.

Without exception patients were very complimentary about the practice staff who they said were friendly, polite and respectful. All the patients we spoke with praised the caring and professional GPs and nurses, their ability to respond to both young and older patients' needs promptly. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines in a way they could understand.

Patients told us that they had got to know the practice staff well, trusted them and felt safe with the care they received. Patients were satisfied with the appointment system and the ability to get appointments to suit their needs. Patients said that they appreciated being able to speak with their GP when they needed to by telephone, or at times of crisis their GP would see them if they called into the practice. There was an online booking system for appointments and the option of seeing a GP at the nearby branch surgery, which was convenient for some of the patients we spoke with.

There had been 95 responses to the patient survey that the practice had conducted in March 2014. This survey showed that 100% of the patients who responded to the question about their overall satisfaction with the practice were either very satisfied or fairly satisfied. The National Patient Survey results showed that 93.9% of the respondents described the overall experience of the practice as good or very good and 92.3% would recommend the practice.

Areas for improvement

Action the service MUST take to improve

- Have a risk assessment and policy for the management and testing of Legionella.
- Carry out a risk assessment around the disposal of any clinical waste generated in consultation rooms.
- Carry out a full audit of the practice in relation to infection prevention and control.
- Provide the lead member of staff for infection control with appropriate training for their role.

Action the service SHOULD take to improve

- Ensure the access needs of patients with disabilities are met including access to a toilet.

Outstanding practice

- The practice had developed a health and education initiative with a local school to identify the needs of children and to improve their health and education outcomes.
- GPs at the practice gave their personal mobile telephone numbers to patients at the end of life so they could continue to provide care out of hours for their patient.
- The practice was aware of the health, social and cultural beliefs of a nearby housed gypsy and traveller community. They had a flexible approach to appointments to ensure GPs made themselves available to see these patients if they attended outside their appointment time.

Twin Oaks Medical Centre

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 and a specialist advisor in practice management.

Background to Twin Oaks Medical Centre

Twin Oaks Medical Centre is located on Ringwood Road in the centre of the village of Bransgore, near Christchurch, Dorset. The practice is on the border of the counties of Hampshire and Dorset and is part of the West Hampshire Clinical Commissioning Group (CCG). The practice operated from purpose built premises which are owned by the GP partners. The practice building has four consulting rooms, and a treatment room. There is space for allied clinical services, such as a midwife and health visitor, to use the consulting rooms. Other health care professionals operate from the premises and share waiting room facilities.

Twin Oaks Medical Centre has a branch surgery called Park View situated in Esdaile Lane, Burley, near Christchurch. A neighbouring village approximately four miles away. The branch surgery also has a dispensary authorised to dispense to patients in the Burley area. We did not inspect the service offered from the Park View branch surgery.

The practice does not provide an Out of Hours service for their patients. Outside advertised surgery times patients are able to access urgent care from an alternative Out of Hours provider.

The practice provides a range of primary medical services to approximately 4,200 patients. Patients are supported by two male and one female GP partners and a female salaried GP. Further support is provided by a practice manager, a practice nurse, an assistant practitioner (a health care assistant who had completed additional training to enable them to provide extended healthcare duties), a dispenser and administrative and reception staff.

Twin Oaks Medical Centre has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Although West Hampshire CCG covers a significantly less deprived area than the average for England; Twin Oaks Medical Centre covers a diverse area. The area includes both some of the least deprived population and some of the areas of highest deprivation in the New Forest.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local NHS England, Healthwatch and West Hampshire Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 4 November 2014. During our visit we spoke with a range of staff including the three GPs working that day, the healthcare practitioner, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 15 comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

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

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

Twin Oaks Medical Centre has a low percentage of their patients in the 20 to 40 age group compared with the average for England. The percentage of patients over the age of 45 registered with this practice is higher than the average for England. The practice population ratio is slightly higher female to male.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to report incidents and near misses. For example when two patients had not received a booked telephone appointment from their GP staff worked together to find an immediate solution to reduce the risk of this happening again.

We reviewed safety records and incident reports and minutes of meetings where these reports were discussed. We reviewed the significant events that had been recorded by the practice over the last 12 months. We saw that safety incidents had been acted on promptly and action had been taken to mitigate future risks. There was evidence that significant events had been handled appropriately to protect the safety and well-being of patients.

We were shown an audit of dispensing errors. This showed that there were 36 errors out of 27,950 prescriptions dispensed in 2012 and 25 errors out of 27,942 in 2013. The practice found that their system had identified all but one of these errors before they left the dispensary. The other error had been picked up by a patient's carer.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records for the last 12 months were made available to us.

The practice held meetings open to all staff every three months to discuss significant events and complaints. There was evidence that changes were made to practice as a result of incidents and complaints and those findings were disseminated to relevant staff verbally or through staff meetings. Systems within the practice had been changed to minimise future risks.

We saw minutes of meetings, where significant events had been discussed. Subsequent meetings reviewed the actions taken and how change was monitored. Significant events and complaints were initially recorded in a book. The practice manager showed us the system they used to oversee manage and monitor them. Evidence of action taken as a result was shown to us.

For example to ensure prescriptions were handed to the correct patient a number of checks had been put in place which included alerts on the electronic records of patients with the same or similar names and spot checks carried out to ensure reception staff were checking dates of birth. Staff, including receptionists, administrators, nursing and dispensary staff were aware of the system for raising issues and felt encouraged to do so.

National Patient Safety Alerts were disseminated to practice staff as soon as they were received by the practice. Any alert or patient safety information was added to the GPs correspondence file which all GPs looked at twice a day. Any patient safety alert was accompanied by a signature sheet for each GP to sign to confirm they had read it. The practice manager kept a copy of all safety alerts. We saw this system in operation on the day of our inspection.

Reliable safety systems and processes including safeguarding

The practice's electronic record system ensured risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP and the other GPs were aware of vulnerable children and adults. Records demonstrated good liaison with partner agencies such as social services and local care homes. GPs had participated in case conferences and in some cases called case conferences to discuss the needs of their patients to improve outcomes for their physical and mental health.

The practice's training records were made available to us. We found that all staff had received training in safeguarding which, we were told, covered safeguarding children and vulnerable adults. All GPs had completed level three training in safeguarding children. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Staff knew how to access the practice safeguarding policy, which GP look the lead for safeguarding and who to speak to in the practice if they had a safeguarding concern. Contact details of the local authority safeguarding team were accessible to all staff who were able to show us where they could be found.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is

a person who accompanies another person to protect them from inappropriate interactions during treatment or examination). Nursing staff, trained reception staff or GPs acted as chaperones when required. There was a female GP available for consultation each day for patients to choose to see should they wish to.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic software system for primary healthcare, which collated all communications about the patient including scanned copies of communications from hospitals. We saw that the practice had a system in place to ensure that all GPs saw all practice correspondence each day and could take immediate action if necessary.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential refrigerator failure. The practice's infection control annual review had documented the actions taken following a breakdown of the vaccine fridge at the main surgery.

Processes were in place to check medicines were within their expiry date and suitable for use. The practice dispenser carried out checks of the medicines at the practice and those in doctors' bags. All the medicines we checked were within their expiry dates. Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available; in date and ready for use should they be needed. Expired and unwanted medicines were disposed of in line with waste regulations.

We saw that the results of a clinical audit into prescribing had been disseminated to GPs and nurses and that action had been taken in response to this audit and patient safety alerts. For example following Medicines and Healthcare Products Regulatory Agency (MHRA) guidance contraindications for patients with cardio vascular disease to be on a certain anti-inflammatory medication were highlighted. It was advised that those patients should have their medication reviewed and altered in line with the latest guidance. The practice's initial audit showed that 81% of patients were identified at risk. A repeat audit showed that 100% of patients affected had been seen and prescribed an alternative medicine.

Vaccines were administered by nurses using patient group directions that had been produced in line with national guidance and we saw up to date copies. We saw evidence that the nurse and assistant practitioner had received appropriate training to administer vaccines. Vaccines administered by the assistant practitioner were done so under patient specific directions.

The practice had a dispenser who worked at the branch surgery's dispensary. We saw that the dispenser had received appropriate training for their role and had received an annual appraisal which included an assessment of their competency for the role.

Patients were able to request repeat prescriptions at the practice or online, patients we spoke with did not have any concerns about the process. The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medications to ensure the medication was still safe and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescriptions were stored securely.

Cleanliness and infection control

We observed the premises to be visibly clean, tidy and well maintained. We saw there were cleaning schedules in place and cleaning records were kept. Work surfaces could be cleaned easily and were clutter free. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had recently appointed a lead for infection control who at the time of our inspection had not taken part in further training to enable them to provide advice on the practice infection control policy or carry out staff training. We saw evidence that the previous lead had carried out the last audit of infection control procedures in September 2012. The practice had produced an infection control annual review in October 2014. This review confirmed that all actions identified at the 2012 audit had been completed. There was also an action plan including recommendations that infection prevention and control (IPC) training was prioritised as only one member of staff had received training in the subject in the preceding 12 months. It was also recommended that IPC was added as a regular agenda item at practice meetings.

Requires improvement

Are services safe?

An infection control policy and supporting procedures were available for staff to refer to. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

We saw there were appropriate waste disposal procedures in place in the treatment room with appropriately labelled clinical waste bins and medicines and sharps waste containers. GP consulting rooms did not have any waste bins dedicated to clinical or hazardous waste. The bins that were available were small swing bins, with domestic bin liners. The practice had a contract with a waste disposal company to collect and dispose of clinical and medicines waste. Waste was stored outside the practice in a designated, unmarked container. We found this storage facility to be locked.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. A hand hygiene review had been carried out for all staff in October 2014.

The practice did not have a policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). The practice building did not have any water storage systems but the risks to patients and staff from Legionella had not been formally assessed.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that medical equipment had been calibrated and was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The majority of staff had worked at the practice for a number of years, the practice manager and GPs told us they felt the stable work force provided a safe environment for their patients. They told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's sickness or annual leave.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Although we could not see a formal audit of the appointment system a member of the administration team told us how they reviewed appointments monthly to ensure there was sufficient capacity to meet the needs of patients.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment and emergency alarms. Fire extinguishers were checked annually and staff underwent annual training in fire safety. Records showed that smoke detectors were checked monthly. The practice manager had a system of spot checks in place for the maintenance and cleanliness of the building.

There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records to show that all staff had received training in resuscitation. All staff asked, knew the location of the automatic external defibrillator (AED) a machine which is used in the emergency treatment of a patient suffering a cardiac arrest, oxygen, and emergency medicines. We were told that emergency equipment was

Requires improvement

Are services safe?

also available at the branch surgery including an AED. We saw that there had been no regularly recorded checks of the AED to ensure it was functioning and ready to use if needed. On the day of our inspection we found it was working and had in date defibrillator pads available.

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. Processes were in place to check emergency medicines were within their expiry date and suitable for use. The practice dispenser checked the emergency medicines and those in doctors' bags were in date to ensure they would be safe to use should an emergency arise.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The practice carried out a risk assessment and had established relationships with local contractors to provide urgent maintenance to minimise the risk of a disruption to the service for patients. All staff were aware of how to access contactors contact details should they need to in an emergency situation, such as the IT provider, an electrician or plumber.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They worked to guidelines from local commissioners and discussed best practice at GP meetings held formally twice a month or during regular informal meetings between the four GPs who worked at the practice. We found from our discussions with the GPs and nurses, that staff completed thorough assessments of patients' needs in line with current guidelines and these were reviewed when appropriate. We saw that National Institute for Health and Care Excellence (NICE) guidance had been used to inform an audit on the use of hormone replacement therapy (HRT) and the frequency of follow up health checks. We found that the GPs at the practice were carrying out annual cholesterol tests for certain groups of patients at a frequency not recommended by NICE guidance of less frequent testing. GPs told us that although they utilised a system that was linked to NICE guidance the practice had no formal system in place to receive NICE guidance.

GPs and nurses remained up-to-date by attending courses in subjects relevant to their practice. We were able to see the records kept by the practice manager of all training courses and educational meetings they had attended. All the GPs and nurses interviewed were aware of their professional responsibilities to maintain their professional knowledge and skills.

One of the GPs at the practice was a GP with a special interest in dermatology (GPSI) the other GPs had areas of personal interest in which they specialised within the practice. They had taken part in further training in areas such as gynaecology, emergency medicine and sports medicine. GPs and nurses were very open about asking for and providing colleagues with advice and support.

The practice referred patients appropriately to secondary and other community care services. National data showed the practice was in line with national standards on referral rates for all conditions. The practice had been successful in commissioning the services of their own midwife from a hospital in a neighbouring county as this practice is situated on the county border this had provided greater continuity of care for patients as the hospital of choice for most patients was in the neighbouring county.

All new patients to the practice were offered a health assessment carried out by the practice nurse to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. If a GP requested a diagnostic test such as a blood test the results would be returned to them electronically. The practice operated a 'buddy system' which ensured that if a GP was not available the GP providing cover checked and acted on any results to avoid any delay to the patient.

The practice provided specialised appointments to meet the needs of patients. These included diabetes, asthma and chronic obstructive pulmonary disease (COPD), a disease which results in breathing difficulties. These specialised appointments were carried out by the practice nurse, who had a specialist qualification in asthma and further relevant training, with support from the GPs. There were arrangements in place to ensure all patients with a long term medical condition received an annual health check.

The practice referred patients appropriately to hospital and other community care services. The practice was aware of the difficulties their patients experienced with accessing community services due to the border location of the practice. They acted on behalf of individual patients to ensure they received the service they needed. National data showed the practice was in line with national standards on referral rates for all conditions

The practice was aware of the top 2% of their patients at most risk of frequent hospital admission. Care plans had been produced for each of these patients. The practice used computerised tools to identify patients with complex needs. The practice held multi-disciplinary meetings twice a month when patients recently discharged from hospital and those patients who required a multi-disciplinary approach to their complex health and social needs were discussed.

Interviews with GPs and staff showed that the culture in the practice was that patients were referred on need and decisions were not adversely influenced by patient age, gender or race.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. The practice undertook regular clinical audits and the Quality and Outcomes Framework (QOF) was used to assess the practice's performance. (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.)

The practice regularly reviewed their achievements against QOF. The practice had strong links with neighbouring practices who they worked with to identify best practice and improve outcomes for their patients. The QOF data was actively monitored at the practice and GPs were made aware of any shortfalls that needed to be addressed. Administration staff were responsible for tracking progress against QOF. QOF data showed the practice performed well in comparison to local practices.

The practice carried out clinical audit cycles to identify areas for change and to ensure they were working to best practice guidelines. We saw evidence of complete clinical audit cycles one of which showed the practice had assessed how effective they were at monitoring patients on hormone replacement therapy (HRT). Also that the safe prescribing of anti-inflammatory medicines had been reviewed and followed current best practice guidelines. Following the audit the findings had been discussed by the practice GPs which included discussing any barriers to change and how to sustain improvement. The practice had carried out other audits, for example prostate cancer and regular audits of minor surgery procedures, cervical smears and family planning procedures with the aim of ensuring procedures were effective and identifying common themes in order to improve patient care.

The practice also used the information collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients diagnosed with dementia whose care had been reviewed in the previous 15 months and those patients with diabetes who had received a test of their cholesterol level in the previous 15 months were in line with the national average. The practice met all standards for QOF in diabetes, asthma and chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF clinical targets.

The practice made use of clinical audit tools, staff appraisal and staff meetings to assess the performance of nursing and dispensary staff. Staff spoke positively about the culture in the practice around audit and quality improvement.

The practice checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and lung disease. The IT system flagged up relevant medicines alerts when the GP prescribed medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending those courses agreed by the practice as mandatory, such as fire safety, safeguarding and resuscitation. A good skill mix was noted amongst the GPs with most having additional qualifications or had attended additional training in areas such as diabetes palliative care, women's health, sports medicine and minor surgery. The practice nurse and healthcare assistant practitioner had attended training or gained further qualifications in subjects such as immunisations, asthma care, diabetes, cytology and cardio vascular disease. The practice nurse had completed training in infection control in December 2013 however there had been no recent training for GPs and the newly appointed healthcare practitioner who was the nominated lead for infection control.

All the staff we spoke with in both nursing and administrative roles told us they were well supported by the GPs and the practice manager. There was an annual appraisal system in place for staff. Staff told us they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. However staff felt that due to the small size of the practice and the close working relationship between all staff they were constantly making suggestions for the smooth running of the practice and discussing their development needs. Staff told us the practice organised staff training in a number of areas and supported staff to attend relevant training.

Good

Are services effective?

(for example, treatment is effective)

GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC). All GPs were aware of their appraisal schedule and revalidation dates. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). All GPs were aware of the appraisal schedule and revalidation dates for their colleagues. Two of the GP partners had completed their revalidation with the other due for revalidation in January 2015.

Working with colleagues and other services

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to use the practice to provide services to patients. These included a podiatrist, chiropractor, a counsellor and psychotherapist.

Antenatal and postnatal care was provided by a practice based midwife and visiting health visitors. We spoke with a patient who told us that their ante natal and post natal care had been shared by the midwife and the GP and that this had worked well for them. GPs and nurses worked closely with health visitors, the community care team, social workers and counsellors. The practice held twice monthly meetings with allied staff; these multidisciplinary meetings were held to discuss the health and social needs of specific patients and were attended by health care professionals as appropriate.

There were systems in place to ensure that the GPs reviewed communication from other health care providers, for their patients. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a procedure for all relevant staff for passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Administration staff collated information in a variety of formats from the Out of Hours provider or from other organisations. All information was collated and passed to all the GPs to see on a twice daily basis. The GPs recorded when they had seen the correspondence. They were able to take immediate action if required; including for those patients whose GP was not available that day.

All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

Information sharing

Patient information was stored securely on the practice's electronic record system. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. We saw that information was transferred to patient records promptly following out of hours or hospital care. The practice retained historic paper patient records which were stored securely and used if necessary to review medical histories.

The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home. Letters and other documents including discharge summaries, out-patient recommendations and shared care agreements about medicines from the local hospitals, out of hour's providers and the ambulance service were received both electronically and by post.

Patients told us that transition from hospital care to care from their GP had been seamless and there had been good communication throughout the process. The practice told us that there was high use of direct choose and book for their patients. (The choose and book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). A patient told us that the GP had supported them during their initial referral to hospital through choose and book which had been organised efficiently by the practice.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue

Good

Are services effective?

(for example, treatment is effective)

for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes. Patients with learning disabilities and those with dementia were supported to make decisions with their families or carers. GPs gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision.

GPs we spoke with demonstrated a clear understanding of Gillick competencies, to identify children aged under 16 years of age who have the capacity to consent to medical examination and treatment and were familiar with using the assessment. The practice website gave information to parents that the practice would withdraw patient access (for making appointments and ordering prescriptions) for parents of children over the age of 12 years. This was because they acknowledged that children of that age were able to give or withhold consent and the practice would not disclose information to parents without the consent of their young patients.

There was a practice policy for documenting consent for specific interventions. For example, written consent was obtained for all minor surgery and some family planning procedures. For other interventions a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

All new patients to the practice were offered a new patient medical with the practice nurse to ensure the practice was aware of their health needs. The GP was informed of any health concerns identified and these were followed-up in a timely manner. GPs and nurses used their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, by offering smoking cessation advice to smokers and promoting appropriate health screening. The practice had offered quit smoking advice and support to 80% of their identified smokers. Similar mechanisms of identifying at risk groups such as those that required specialist health screening or patients who had chronic disease. These groups were offered further support in line with their needs. The practice proactively followed up those patients who did not attend for routine screening. For example those women who failed to attend for cervical screening were sent three reminder letters by the practice followed by a personal telephone call from the GP with responsibility for women's health.

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations, community schemes such as exercise classes The practice brochure was available for new patients and information about the practice and health promotion was also available on their website.

Practice nurses had specialist training and skills, for example in the treatment of lung disease, diabetes and travel vaccinations. The practice offered a full travel vaccination service including yellow fever. This enabled nurses to advise patients about the management of their own health in these specialist areas.

The practice had a good knowledge of all their patients with a learning disability. Patients with a learning disability were offered a physical health check, however not all had received a health check in the past 12 months. Additionally the practice staff knew those patients in vulnerable circumstances. Practice staff were aware of the cultural and physical barriers to healthcare experienced by these groups of patients. The GPs had set up a joint health and education working initiative with the local school to improve educational outcomes for those children who did not attend school regularly through health or social problems. They worked closely with health and social workers to improve patient education.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. The practice offered flu vaccinations in line with current national guidance. Patients told us that the practice publicised the vaccinations well and we heard reception staff offering flu vaccinations to those patients that were identified as eligible on their electronic appointment system.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with nine patients and reviewed 15 comment cards. Everybody was complementary about the care that they received from all the practice staff. We spoke with patients of all ages. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey, NHS Choices and the practice's own satisfaction survey conducted in March 2014. The evidence from all these sources showed patients were very satisfied with how they were treated and described the staff as friendly, caring and efficient. The practice shared with us the most recent results from NHS England's July 2014 patient survey. Satisfaction scores on consultations with doctors and nurses showed that 97% of practice respondents said their GP was good or very good at listening to them and 97% said the GP gave them enough time. The survey also showed the practice scored highly in caring related questions for example 93% of respondents said the last GP they saw or spoke to was either good or very good at treating them with care and concern.

Staff told us how they respected patients' confidentiality and privacy. All telephone calls were made and answered by staff who were not sitting at the reception desk this helped keep patient information private and ensured that confidential information could not be overheard. We saw this in operation during our inspection and noted that it was effective in maintaining confidentiality. All staff had taken part in information governance training, although this was in November 2012 those we asked were able to demonstrate how they ensured patients' privacy and confidentiality was maintained.

Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice very highly in these areas. For example, data from the national GP survey showed 93% of respondents rated their GP as good or very good at explaining tests and treatment.

Patients we spoke with on the day of our inspection told us that their GP explained their treatment and all commented that there was enough time to discuss their needs. They also told us they felt listened to and supported by staff. They understood what had been said in order to make an informed decision about the choice of treatment they wished to receive. The comment cards we received were also positive and praised the caring, helpful attitude of staff.

Patient/carer support to cope emotionally with care and treatment

We saw minutes of multi-disciplinary meetings. GPs had discussed newly diagnosed patients and the support they may need. GPs told us that they involved families and carers in end of life care and worked to provide help and support for those patients at the end of life. The practice carried out an annual audit of deaths with the aim of identifying if all was being done to ensure patients had a good death and if they had been supported in line with their wishes. Recent patient deaths were discussed at the practice's multidisciplinary meetings which included how bereaved families could be provided with the support they may need. Patients at risk of hospital admission or needing end of life care were also discussed and how emotional support could be provided to them and their families in collaboration with representatives from the community nursing team and community palliative care nurses. GPs offered personal visits to bereaved families and suggested if appropriate referrals to national support organisations or local counselling services.

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs and ensured they received specific patient notes. This included individualised information about patient's complex health, social care or end of life needs. The practice supported their patients with end of life care in their own home if it was the patients wish to die at home

Good

Are services caring?

rather than in hospital. GPs at the practice gave their personal mobile telephone numbers to patients at end of life so they could continue to provide care out of hours for their patient. This was confirmed by one of the patients we spoke with who said that their GP called in regularly to see a family member who was receiving palliative care. They told us they did not have to ask for visits their GP visited to check if they needed anything or to provide support to them as a carer. They also commented positively on the caring and supportive reception staff who had supported them emotionally when needed.

Notices in the waiting room sign posted patients to a number of local support groups and organisations. For example lunch clubs for older people and a local community care club who were able to provide patient transport which was often difficult in the rural area. The practice staff worked closely with these community organisations to improve outcomes for their patients. The practice recorded if a patient had caring responsibilities.

Practice staff were aware of individual patient needs through their local knowledge and provided personal support such as delivering prescriptions to people's homes if patients are unable to arrange collection. They also supported a local housed gypsy and traveller community by communicating between them and the hospital when necessary.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Whenever possible patients were offered the GP of their choice or were directed to the GP who, through a special interest or extended training, was best able to meet their needs. All patients over 75 had a named GP in line with current recommendations. The practice felt this ensured continuity of care when necessary or specialised care and treatment if needed. Home visits were regularly made to local care homes.

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. The practice had responded to the needs of the practice population. The practice and its branch surgery served a semi-rural community and the staff were aware of the different patient populations each one served. Services were planned to take into account the needs of the community. The branch surgery in Burley had its own dispensary which the practice was supported to set up in 1996 to serve the small population that could not sustain a pharmacy business. The dispensary could be used by all the patients living in the Burley area where the patients were older and the public transport links were poor.

Staff told us that the population groups varied between the main practice and the branch. The main practice covered an area where more young families lived and had responded to the different patient needs. For example by arranging midwife appointments at the main surgery.

The practice had a number of patients of working age. Extended hours opening until 7.30 pm were available each Monday. There was an early morning surgery from 7.30am on Tuesdays and Thursdays for patients who could not attend during working hours due to work commitments, lunchtime appointments were also offered if patients needed to be seen by a GP the same day. During our inspection we spoke with nine patients and reviewed 15 comment cards. They all commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the practice.

The practice served an area where a housed gypsy and traveller community lived. The practice was aware of the community's cultural beliefs in relation to health care and GPs and nurses were able to describe the systems they had in place to meet the needs of these patients. This included a flexible approach to appointments which ensured that GPs made themselves available to see these patients if they attended outside their appointment time and how they ensured the patients did not leave before seeing the GP or nurse.

The practice had a high number of older patients for who blood tests were often required. A phlebotomist (a person who has been trained to take blood samples) was available at the practice and branch surgery to take blood samples for patients. This service meant patients did not have to travel long distances to the hospital for any diagnostic blood tests. Additionally, to avoid journeys to the general hospital, accident and emergency or minor injuries, the practice was able to offer minor surgery and minor injury treatment. The practice area covered a number of holiday camp sites and an outdoor activities centre and provided temporary resident care and minor injury treatment for patients from these holiday sites.

The practice worked collaboratively with West Hampshire Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example ideas for improving the service and managing delivery of community care in rural areas and the issues associated with providing care in an area on the border of two CCGs.

The practice had a patient participation group (PPG). The practice's patient feedback survey had been designed based on issues raised by the group. The PRG had been consulted about the questions for the annual patient survey carried out in March 2014. Most of the questions for that survey were aimed at gaining patients' opinions on the appointment system and access to appointments. Following the survey the PPG had agreed a plan of action with the practice for changes and in response to the outcome of the survey. This included the promotion of the online appointment booking service and telephone consultations. We saw that the most recent practice newsletter and the practice website gave patients the information they needed to access the on line system. The practice manager told us that the practice was constantly reviewing the appointment system following feedback from patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services for the needs of a semi-rural community.

The practice had two care homes and a residential and care centre for adults with a learning disability for who they provided health care. The practice provided health checks for their patients who had a learning disability and provided home visits for patients in the care homes.

Staff had not received formal training in equality and diversity; however they could demonstrate that they promoted equality in the practice.

The premises were purpose built; we saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. However the premises did not allow for independent access for any patient who used a wheelchair or had mobility issues although there was a bell for patients to summon assistance. The reception area was at a high level which could be a barrier to anybody who used a wheelchair, reception staff would have to stand up and lean over to communicate with these people. Patient toilets were available but these were not accessible to any patient in a wheelchair. At the time of our inspection staff told us that they only had a very small number of patients who used a wheelchair however the patient toilet would be difficult to use for any patient with other mobility issues. A patient attending in a wheelchair told us that they tried to ensure they would not need this facility when attending their appointment but did not know what they would do in an emergency. There was access to the ground floor treatment and consultation rooms for all patients.

Access to the service

Information relating to the practice opening hours was available on the practice website and in the practice booklet. These gave information for patients on how they could book appointments online, by telephone, or in person and how to organise repeat prescriptions online, by post, at the surgery or by fax. Opening hours were from 8am to 6.30pm with appointments available from 9 am. Some appointments were available from 7.30am on Tuesdays and Thursdays and there were late appointments until 7.30pm on Mondays. Patients were able to request a telephone consultation with a GP who allocated time at the end of their surgery to call patients. Two of the GPs had extended their appointment length to 15 minutes to ensure they had sufficient time to deal effectively with patients' problems. This had also improved waiting times for patients with the GPs continuing to provide the same number of consultations each day.

Patients told us they had not encountered any problems making appointments when they needed them. They told us that they were able to get emergency appointments on the day they needed but sometimes had to wait a few days to get a routine appointment or to see the GP of their choice. We spoke with ten patients and looked at feedback that had been left on NHS choices and reviewed 15 comment cards. All patients told us they could access a GP when they needed to. Patients were clear about how the practice operated their appointment system.

There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. This was provided by an out-of-hours service. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was also provided to patients in the practice booklet and on the website.

The practice was also able to care for patients with minor injuries which reduced the need for patients to visit accident and emergency (A & E) or the minor injuries department at the local hospital. The GPs were available and trained in minor surgery and minor injuries. This was provided to their registered patients and to those who attended as temporary patients holidaying in the area.

Listening and learning from concerns and complaints

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

Accessible information was provided to help patients understand the complaints system this was set out in the practice leaflet, on the practice website and displayed in the practice.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and

Good

Are services responsive to people's needs?

(for example, to feedback?)

whistleblowing, showed that the practice responded quickly to issues raised. We looked at the four complaints that had been received in the last 12 months and found these were dealt with appropriately by the practice. There was a detailed record of the concerns raised, a thorough investigation carried out and remedial actions and learning outcomes noted and disseminated to all staff to ensure all staff were able to learn and contribute to improvements at the practice.

The practice regularly analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback. Complaints were a regular agenda item and discussed at significant events meetings.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. Their ethos was to make healthcare easy to access in a friendly non-judgemental way and to provide high clinical outcomes. The GP partners promoted an open culture and teamwork where each person played their role. They told us they hoped to provide an enjoyable place for all their staff to work. This was confirmed by staff who told us they enjoyed their role and felt valued. Decisions were made democratically and patient care was frequently shared by GPs.

We spoke with three GPs, the healthcare assistant practitioner, the practice manager and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these.

All staff felt able to make suggestions to improve outcomes for patients for example in relation to appointment systems or from personal research or learning. GPs used twice monthly multi-disciplinary meetings to share and discuss information to improve effective patient care. The GPs said they also met regularly on an informal basis to share and discuss information to improve effective patient care

Patients described the practice as caring and friendly and they had no concerns regarding accessibility to a GP or practice nurse.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. The practice used the Quality and Outcomes Framework (QOF) to measure their performance and to monitor the effectiveness of some aspects of the practice, for example the identification of disease and how they were performing against their targets for screening programmes and health education. The QOF data for this practice showed it was performing in line with national standards. We were told that QOF data was regularly discussed, monitored and reviewed by the GPs, practice manager and staff to maintain or improve outcomes. However no record of those discussions was available. The practice manager told us that they met with other practice managers from the West Hampshire Clinical Commissioning Group (CCG). The practice manager along with the senior GP partner also attended monthly meetings with the CCG. This gave the practice the opportunity to measure their service against others and work collaboratively to identify best practice.

Clinical audits were regularly undertaken by the practice GPs. We saw evidence of completed audit cycles, such as prostate cancer and hormone replacement therapy and a plan of frequent and annual audits for example inadequate smears and coil insertions to show they were continually auditing their procedures. The practice manager and GPs demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example the GP partners took lead roles for certain clinical conditions such as diabetes, epilepsy and hypertension. There was a lead for infection control and one of the partners was the lead for safeguarding and another was the lead for medicines management and human resources. The partner GPs worked together with the practice manager to make decisions relating to the practice. The GPs had a collective responsibility monitoring the effectiveness of clinical practice through audits or specialist training. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing administration and reception staff.

The leadership was established at the practice as two of the GP partners had been in their roles for a number of years. All the staff we spoke with told us they felt supported by the practice manager and GPs. All staff confirmed there was an open culture and felt that they could question each other about their working practices. Staff we spoke with felt able to talk with any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and that they were provided with opportunities for development and training.

We saw records of appraisals which were carried out annually with training supported by the GP partners and practice management. We saw that serious events were reported and discussed at significant event meetings for

Are services well-led?

Good

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

assurance that they had been dealt with appropriately and not to apportion blame. Staff informed us that communication across the service was good with information shared appropriately.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example; the recruitment policy, the equal opportunities policy and the whistle blowing policy all of which were in place to support staff. We were shown copies of operational procedures and protocols such as first aid, data protection and repeat prescribing.

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

The practice had gathered feedback from patients through the national patient survey, their patient participation group survey, the NHS Choices website and patient compliments and complaints.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff told us that they were encouraged to make suggestions for the improvement of the practice and they regularly discussed how procedures could be improved. The practice had a whistle blowing policy which had been updated in November 2014 and was available to all staff and included the contact details of a confidential helpline.

The practice had a patient participation group (PPG) with representatives from all ages of the patient population. The practice website invited all patients to join the PPG (a patient participation group is a group of patients who have agreed to be contacted for their views thoughts and opinions of the practice). There had been 95 responses in the patient survey which was conducted in March 2014. The survey questions had been developed collaboratively with the PPG and distributed to patients via email, on the practice website or given to patients when they attended either of the surgeries. Questions were focused on the access to GP consultations for patients, including the introduction of on line appointment booking and the patients' opinions on telephone appointments. The practice showed us the analysis of the survey and the action plan which had been developed and discussed with the PPG. The results and actions of the survey were available for patients on the practice website.

We looked at the results of the national patient survey. The proportion of respondents to this survey who described the overall experience of their GP surgery as good or very good was over 93% and 94% rating their experience of making an appointment either good or very good.

We saw that the results of the practices own survey had been analysed and an action plan was in place to address any areas for improvement.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that regular appraisals took place; staff told us that the practice was very supportive of training and where possible training took place at the practice. However the assistant practitioner who had become the lead for infection control in July 2014 had not, at the time of our inspection received specific training for this role.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally, as appropriate, to ensure the practice improved outcomes for patients. For example GPs and administration staff had discussed how they could ensure that requests for telephone consultations were not missed. All staff were able to contribute to the learning process and to make suggestions for future training. The practice staff told us that they all worked together to provide solutions to problems.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control We found a clean and well maintained building. However improvements were needed to the systems and processes in relation to infection control. The practice had not risk assessed the need for the safe disposal of waste nor the risks relating to Legionella. The lead member of staff for infection control had not received training for the role. How the regulation was not being met: The provider had not ensured that patients were protected against identifiable risks of acquiring a health care associated infection by the effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of infection. Regulation 12 (1) (a) (2) (a)