New Milton Health Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at New Milton Health Centre on 5 January 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Patient feedback was consistently positive.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients 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 made use of electronic ways of accessing advice and treatment. Patients that worked commented on how useful they found this service.
- 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 and complied with the requirements of the duty of candour.
- The practice used care registers to identify those patients in need of additional support and assistance. For example, 97% of the 59 patients diagnosed with a learning disability had received an annual health check in the last 12 months.
- There was an innovative approach to delivery of care and the practice piloted new services. For example, it had led in the development of single patient record with other health providers in the locality.

Summary of findings

- There was a focus on the needs of each population group registered and recognition of the higher than average elderly population. For example, one GP specialised in care of the frail elderly.
- The practice demonstrated a commitment to health promotion and prevention of poor health. Nationally reported data showed effective performance in delivering smoking cessation advice and in monitoring blood pressure to prevent further health problems developing.
- The practice was proactive in identifying patients with caring responsibilities and delivering advice and support to this group.

We saw one area of outstanding practice:

- Governance and performance was kept under regular review by use of a 36 point key performance indicator programme. Services were adjusted when the need for further improvement was identified, such as appointments could be added at times of peak demand. The KPI's had enabled the practice to match resources to demand by closely monitoring practice performance.

The areas where the provider should make improvement are:

- Ensure that blank prescription stationery tracking identifies which prescriber or clinical room prescriptions have been issued to.
- Ensure all responses to complaints detail the route to escalate a complaint if the patient feels it necessary to do so.
- Ensure a review of exception reporting for patients diagnosed with diabetes is undertaken.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed. Risk assessments were kept under regular review and a monthly environmental safety check was undertaken.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average. For example, the practice had achieved 100% of the QOF indicators in 2015/16. However, the practice exception rates were higher for some indicators than local and national averages. The practice was able to demonstrate clinical rationale for this in the majority of indicators. The number of patients aged over 85 years was more than double the national average which led to some patients being assessed as to frail to receive the relevant tests and treatments or declining these. However further review of exception rates for patients with long term conditions is needed.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.

Summary of findings

- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs. For example, there was close working between one of the GPs and the consultant specialists from the local hospital regarding the care of the elderly.
- The practice used care registers to identify those in need of additional support and assistance. For example, 97% of the 59 patients diagnosed with a learning disability had received an annual health check in the last 12 months.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice had identified approximately 3% of their registered patients as having caring responsibilities. These patients were offered relevant support and advice. They were also offered an annual health check and a flu immunisation.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, the practice had developed a dementia café in conjunction with a care home specialising in care of the elderly with mental health problems.
- There are innovative approaches to providing integrated patient-centred care. For example, in developing the shared single patient record with care homes and other NHS services in the area.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, providing blood pressure monitoring machines for patients to monitor their own blood pressure.

Summary of findings

- Patients can access appointments and services in a way and at a time that suits them. Including e-consultations, e-mail exchange between patients and GPs, telephone consultations, routine appointments and on the day urgent appointments. Patients who completed comment cards complimented the practice on access to appointments.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example, in providing opportunities for staff, employed by the CCG on a pilot project, including a care navigator and clinical pharmacist to work at the practice. This extended the range of services available to patients.
- A wide range of NHS services, for example, podiatry and physiotherapy, were available on site reducing the need for costly and time consuming trips for patients to hospitals and other clinics.

Are services well-led?

Good

The practice is rated good for being well led.

- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. For example, partner GPs took lead roles in both management and clinical governance. The practice recognised the needs of their population by appointing a GP as lead for care of the frail elderly.
- Governance and performance was kept under regular review by the use of a 36 point key performance indicator programme. Services were adjusted when the need for further improvement was identified such as adding appointments at times of peak demand.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- One of the GPs had undertaken additional training that enabled them to specialise in care of the frail elderly.
- The practice GPs supported patients that lived in 23 local care homes.
- There was a high level of home visiting to meet the needs of patients who could not attend the practice. Data showed there was an average of 20 visits per day.
- Care plans were agreed with the most frail and elderly 2% of the population.
- The practice worked with a care navigator to identify and meet the needs of elderly patients requiring support in their day to day living and with attendance at appointments.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was 100% which was above both the clinical commissioning group (CCG) average of 93% and national average of 90%. For example, 97% of patients diagnosed with diabetes achieved target blood pressure compared to the CCG and national average of 91%.
- All patients diagnosed with coronary heart disease, COPD (a type of lung disease) and Asthma had received a review of their medicines in the last twelve months.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people.

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 87%, which was comparable to the CCG average of 82% and the national average of 81%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives and health visitors.
- The practice website held an identified section for younger patients called 'teenzone' that contained health advice and information specific to this patient group.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Patients who completed CQC comment cards complimented the range of electronic services provided.
- Physiotherapy services were available on site.
- The practice was a partner in the development of the local care hub that offered 8am to 8pm care seven days a week.
- Extended hours appointments were available on two mornings and two evenings every week.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. Of the 59 patients registered who were diagnosed with a learning disability, 57 had care plans agreed.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- Approximately 3% of the practice population had been identified as holding caring responsibilities. They were offered relevant advice and support by the practice team.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- Performance for mental health related indicators was 100%. This was above the CCG average of 95% and national average of 93%. For example, the GPs had agreed care plans with 97% of patients diagnosed with long term mental health problems in the last 12 months. This was better than the CCG and national average of 89%. This performance was achieved with a low exception rate of 2% of the patients compared to the CCG average of 14% and national average of 13%.
- The practice had developed a dementia café in conjunction with a local care home as a drop in service for patients with dementia and their carers. This was held once a month at the practice and GPs, practice nurses and the care navigator made themselves available to offer advice and support to the patients and their carers.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. Close working with the local adult mental health team was in place with this team available in the health centre.

Summary of findings

- The practice carried out advance care planning for patients with dementia. They also offered screening to 214 patients for early dementia that had been accepted by 197 patients in the last 12 months.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. The practice is accredited as dementia friendly and was an active member of the local initiative of 'New Milton Dementia Friendly Town'.
- There were examples of patients with mental health problems being given additional support to make their appointments.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. They were from surveys that were undertaken between July and September 2015 and January to March 2016. The results showed the practice was performing better than local and national averages. There were 220 survey forms distributed of which 125 were returned. This represented 1.2% of the practice's patient list and a 57% response rate.

- 93% of patients found it easy to get through to this practice by phone compared to the local clinical commissioning group (CCG) average of 80% and national average of 73%.
- 90% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the CCG average of 89% and national average of 76%.
- 89% of patients described the overall experience of this GP practice as good compared to the CCG average of 88% and national average of 85%.
- 82% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the CCG average of 82% and national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 42 comment cards which were all positive about the standard of care received. There were 41 of these comment cards that were wholly positive with the majority of patients describing their experience of the practice as excellent. These patients also commented that they were able to access appointments on days and times that were convenient for them. One patient commented that they had encountered problems obtaining appointments.

We spoke with seven patients during the inspection. All seven were complimentary about the personalised services they received from their usual GPs at the practice. They were also very positive about all staff being professional, helpful and friendly.

The practice encouraged their patients to take part in the national Friends and Family Test. This asks patients whether they would recommend the practice to others. We reviewed the friends and family test data for five months between June to November 2016 (October data was not available). During that time 526 patients had completed the test and 456 (87%) said they would recommend the practice.

New Milton Health 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 specialist adviser.

Background to New Milton Health Centre

New Milton Health Centre is a purpose built medical facility. The practice shares the premises with a range of other health clinics including for example, talking therapies and specialist dental services. The health centre is close to public transport links and there are disabled parking facilities available. All consulting and treatment rooms are on the ground floor and the premises are accessible to patients that use wheelchairs or have mobility problems.

The practice has a registered patient population of approximately 9,900. Data shows that there is a significantly higher than average number of patients registered over the age of 65 and far fewer than average under the age of 50. For example there are more than double the national average of patients aged over 85 registered with the practice. The practice has patients registered with them that live in 23 care homes in the locality. Whilst nationally reported data shows limited income deprivation in the locality, the practice is aware that this is an issue in parts of the area it serves. The practice provides services to the registered population via a General Medical Services (GMS) contract. (A GMS contract is the most common type of contract and is negotiated nationally with NHS England)

There are seven GP partners (three male and four female) at the practice. They are equivalent to 4.75 whole time GPs. The practice is accredited to provide training to qualified doctors who are seeking to become GPs. At the time of inspection there were two trainee GPs at the practice. There are six members of the practice nursing team. Four are practice nurses of whom two are qualified to prescribe an approved range of medicines for patients with minor illnesses and long term conditions. The nurses are supported by two health care assistants (HCAs). The day to day management of the practice is led by the practice manager who is supported by a team of 25 administration and reception staff.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.30am to 12pm every morning and 2.30pm to 6.20pm daily. Extended hours appointments were offered from 7.30am on both Wednesday and Thursday and until 7pm on a Monday and Wednesday.

The practice has opted out of providing out of hours services to their patients. Out of hours services are provided by the local out of hours provider Partnering Health Limited (Hampshire Doctors on Call)). The out of hours service is accessed by calling NHS 111. The arrangements in place for services to be provided when the surgery is closed are displayed at the practice and in the practice information leaflet.

All services are provided from: New Milton Health Centre, Spencer Road, New Milton, Hampshire, BH25 6EN.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 January 2017.

During our visit we:

- Spoke with four GPs, a registrar, two practice nurses and three members of the administration/reception team. We also asked four members of the administration staff to complete and return staff questionnaires.
- Also spoke with five patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public 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 were provided for specific groups of patients and what good care looked like for them. The population groups are:

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

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.

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice recorded an incident of a power failure causing vaccine fridges to operate outside of optimum temperature range. The practice took appropriate action to ensure vaccines that were compromised were not administered to patients. They also reviewed their cold chain maintenance procedures and policy, shared this with staff, and installed a secondary means of recording fridge temperatures to maintain more accurate monitoring.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. The two nurse practitioners were also trained to level three in child protection and safeguarding. All staff had completed training in safeguarding of vulnerable adults.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams. This ensured prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored. There was a system in place to monitor their use but this did not identify which prescriber had received specific batches of serial numbered prescriptions. Two of the nurses were qualified as Independent Prescribers and were able to prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role. Patient Group Directions (PGDs) had been adopted by the practice to

allow nurses to administer medicines in line with legislation. However, we found the PGDs for travel vaccinations had not been appropriately signed and authorised. We raised this with the practice and it was corrected immediately. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- We reviewed seven personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available. However, we found that these results were achieved with higher than average exception rates for a number of the indicators of care for patients with long term medical conditions. For example, the exception rate for patients newly diagnosed with diabetes referred to an education programme was 61% which was significantly higher than the CCG average of 26% and national average of 23%. There was also a higher than average exception rate of patients diagnosed with COPD (a type of lung disease) receiving an annual assessment of their breathlessness at 18% compared to the CCG average of 15% and national average of 11%. Overall the practice exception rate for all indicators was 14% compared to the CCG average of 11% and national average of 10% (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The GP advisor reviewed the areas of high exception rates in detail. The practice could demonstrate why patients had been removed from the indicator targets. For example, the local service that provided education programmes for newly diagnosed diabetics had not been accepting referrals. Therefore, these patients could not attend this programme.

Another example was, the high numbers of elderly frail patients living in care homes whose frailty prevented them receiving a range of tests and treatments required to attain the QOF targets.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from April 2015 to March 2016 showed:

- Performance for diabetes related indicators was 100% which was above both the clinical commissioning group (CCG) average of 93% and national average of 90%. For example, 97% of patients diagnosed with diabetes achieved target blood pressure compared to the CCG and national average of 91%. The higher than average exception rates were reviewed and the practice had recorded the reasons such as in some cases elderly patients declined the relevant tests or were assessed as too frail to receive tests and treatments.
- Performance for mental health related indicators was 100%. This was above the CCG average of 95% and national average of 93%. For example, the GPs had agreed care plans with 97% of patients diagnosed with long term mental health problems in the last 12 months. This was better than the CCG and national average of 89%. This performance was achieved with a low exception rate of 2% of the patients compared to the CCG average of 14% and national average of 13%.

  There was evidence of quality improvement including clinical audit.

- There had been eight clinical audits undertaken in the last two years. We saw that two of these, related to prescribing, were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation and peer review.
- Findings were used by the practice to improve services. For example, a first audit was undertaken to identify that patients taking anti-inflammatory medicines on a long term basis had received a blood test to check their kidney function. (The kidneys can be affected adversely by use of anti-inflammatory medicines). The first audit identified 158 patients who had not had the blood test and a further 83 who had taken the blood test but needed to repeat it. GPs were updated to remind

patients of the benefits of having the blood test. A recall system was put in place. The second audit showed that all 241 patients identified as requiring the blood test from the first audit had completed their blood tests. GPs took action on the results of the blood tests when this was required.

The practice monitored their performance by use of a set of 36 key performance indicators (KPIs) that covered a wide range of measures. These included;

- Monitoring staff absence
- The number of home visits undertaken
- Availability of appointments
- Missed appointments
- The number of complaints received
- The number of significant events recorded

The KPIs were prepared each month and showed annual trends. They were used to identify any issues upon which the practice needed to take action to further improve delivery of patient services. For example, if demand for appointments was surpassing supply or if significant event reporting had increased. The practice had used this performance monitoring system for approximately two years. It identified when more staff were required to meet patient needs and supported trend analysis. The practice could, for example, take steps to reduce non-attendance for appointments by using the performance analysis.

Information about patients' outcomes was used to make improvements such as, ensuring patients prescribed repeat medicines received relevant reviews to support their continued safe use of the medicines. Data showed high levels of medicine reviews taking place. For example, 100% of patients diagnosed with asthma had a medicine review in the last year.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. For example, one of the practice nurses attended update training in the care and treatment of patients diagnosed with respiratory diseases.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff, who had been employed for over a year, had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

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

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

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

- Staff clearly understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young patients, staff carried out assessments of capacity to consent in line with relevant guidance. Staff demonstrated a detailed understanding of these requirements.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were supported by the practice. They either received support from the GPs and nurses directly or were signposted to the relevant service.
- Smoking cessation advice was available from a local support group that visited the practice every week. Data showed that 98% of patients with a range of long term conditions had received advice on the benefits of stopping smoking compared to the national average of 96%. The practice identified 1339 patients aged over 16 who were smokers and 1078 (81%) had been offered advice on stopping smoking. In addition, 13 patients had accepted referral to the smoking cessation service in the last 12 months.
- The practice undertook blood pressure monitoring of patients aged over 45. In the last five years, 93% of this group of patients had their blood pressure monitored compared to the CCG average of 90% and national average of 91%. The practice encouraged self monitoring of blood pressure by offering two self monitoring blood pressure machines located in the practice. Instructions on how to use these and what to do with the result were clearly displayed. High blood pressure can be an indicator of cardio-vascular (circulation and heart) problems.

The practice's uptake for the cervical screening programme was 87%, which was comparable to the CCG average of 82% and the national average of 81%. The practice had an 11% exception rate compared to the CCG average of 5% and national average of 7%. The GP advisor reviewed records for a sample of the patients who had been exempted from this screening programme. They found that the exceptions were made for appropriate reasons. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by ensuring a female sample taker was available. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. In the last three years, 76% of eligible female patients had attended for breast cancer screening compared to a CCG average of 73% and national average of 72%. Of the patients eligible for the national bowel cancer screening programme, 65% had completed the screening in the last 30 months. This was similar to the CCG average take up of 66% and above the national average of 58%.

Childhood immunisation rates for the vaccinations given were comparable to CCG and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds were 9.7 compared to the national average of 9.1. Of the children aged five, 98% had received their second measles mumps and rubella (MMR) immunisation compared to the CCG average of 89% and national average of 88%.

There were 59 patients registered who were diagnosed with a learning disability. The GPs at the practice had undertaken annual health checks for 57 (97%) of these patients in the last year. We also noted that 57 patients with a learning disability had a care plan in place that had been reviewed with them, or their carers, within the last year. Research showed shows that this group of patients were more likely to develop physical health problems and benefitted from regular reviews of their physical health.

Good

Are services effective?

(for example, treatment is effective)

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

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

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

All of the 42 patient Care Quality Commission comment cards we received were positive about the care experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was similar to local and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 92% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 90% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 87%.
- 93% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared to CCG average of 88% and the national average of 85%.
- 87% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 91%.
- 90% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 90% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and the national average of 86%.
- 87% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 82%.

However,

- 82% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 85%.

We noted that the national survey had been taken when there was a vacancy for a practice nurse. At that time there were fewer appointments available with the nurses whilst recruitment to the vacancy was undertaken.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language.

Good

Are services caring?

We saw notices in the reception areas informing patients this service was available. We were given examples of information about the benefits of childhood immunisations being translated into Czech, and the procedure for fitting intrauterine contraceptive devices (coils) being translated into Bengali, for patients whose first language was not English.

- A range of information leaflets were available.
- GPs were able to provide condition specific information leaflets for patients to support the verbal explanation given at the time of consultation.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 280 patients as carers (which was approximately 3% of the practice list). The register enabled GPs and nurses to recall carers for an annual health review and offer them an annual flu immunisation. It also enabled the GPs to offer advice to these patients about support organisations in the local area. We were given examples of carers being contacted by the care navigator to ascertain if the person they cared for required any additional services or aids and adaptations to help them in their daily lives. Written information was available to direct carers to the various avenues of support available to them. There was also a noticeboard in the waiting room that held information that could be of interest to carers and detailed how to register as a carer.

Staff told us that if families had suffered bereavement a sympathy card was sent when appropriate. The families usual GP was informed and they made a decision whether to offer 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

- The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. The practice had been instrumental in developing a dementia café that took place at the health centre once a month. Patients registered at the practice and people from other practices could access this service that was instituted in partnership with a local care home specialising in the care of the elderly with mental health problems. GPs, the care navigator and practice nurses attended when the café was open to offer advice and support to this group of patients.
- The practice offered extended hours clinics on two mornings and two evenings every week. The early morning clinics started at 7.30am and the two evening clinics ran until 7pm. These were of assistance to working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- GPs visited patients that lived in 23 care homes in the area.
- Same day appointments were available for children and those patients with medical problems that require same day consultation. We received 15 comment cards from patients who made specific mention about always getting an appointment at a time that met their needs.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were accessible facilities, a hearing loop and translation services available. Staff gave us examples of when the translation service had been used.
- The practice offered a range of online services including online appointment booking and electronic prescribing. Six patients who completed comment cards referred to electronic systems helping them access services during their working hours.
- There were examples of how the practice assisted patients with complex needs to access the service. We were given an example of a patient who found it difficult to make appointments meeting their GP outside of the practice. The GP agreed a time for the patient to attend an appointment and made the appointment booking for the patient.
- The practice piloted, and continued to offer, e-consultations whereby patients who could not attend the practice for an appointment shared their information with GPs electronically. The practice was identified as a centre of excellence for this service and assisted others to develop similar services.
- A part time clinical pharmacist, who also worked at other practices, was available for appointments with patients requiring repeat prescription reviews and long term condition reviews.
- The practice website held an identified section for younger patients called 'teenzone' that contained health advice and information specific to this patient group.
- Additional NHS services were available at the health centre including; podiatry, dental care for patients with complex needs and those with a learning disability, physiotherapy, new born hearing assessments, speech and language therapy and the adult mental health team. Patients registered with the practice benefitted from these services by reducing the need to attend hospitals and clinics elsewhere.
- The GPs and practice nurses provided daily urgent care services. The responsibilities for urgent care were shared between the team ensuring that patients were also able to access their usual GP for routine appointments.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from 8.30am to 12pm every morning and 2.30pm to 6.20pm daily. Extended hours appointments were offered from 7.30am on both Wednesday and Thursday and until 7pm on a Monday and Wednesday. In addition to pre-bookable appointments that could be booked up to four weeks in advance, urgent appointments were also available for patients that needed them.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 93% of patients found it easy to get through to this practice by phone compared to the local clinical commissioning group (CCG) average of 80% and national average of 73%.
- 81% of patients were satisfied with the practices opening hours compared to the CCG and national average of 76%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them. The practice was able to demonstrate flexibility in resources that enabled additional appointments to be made available at times of peak demand.

The practice had a system in place to assess:

- Whether a home visit was clinically necessary; and
- The urgency of the need for medical attention.

Reception staff received requests for home visits and recorded these on an electronic list for GPs to review. The GPs assessed urgency and called patients to obtain further information to enable advice to be given or prioritisation of the visit. Once visits were agreed they were shared between the GPs on duty. The practice operated a system whereby one GP was designated to deal with urgent demand for appointments each day. This GP was responsible for undertaking requests for home visits each weekday afternoon. They ensured home visits were completed before the practice handed responsibility to the out of hours service at 6.30pm. In rare cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. Details of the complaints system were displayed at the practice, on the practice website and in the patient leaflet.

We looked at four complaints received in 2016 and found all four had been dealt with in a timely manner following investigation of the patient's concerns. The patient received either a verbal or written detailed response. However, we noted the practice did not always offer the patient information about how to escalate their concerns should they feel it necessary to do so. Following the inspection the practice sent us a revised letter template for their response to complaints that included reference to escalation routes. We received this within two days of the inspection.

Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, the practice purchased disposable tape measures to ensure that the size of moles and skin lumps were monitored. This action was taken following a referral of a patient who presented with a skin lump.Once referred the patient was not followed up by the GP and the patient complained that their diagnosis was delayed because neither hospital nor practice had monitored the progress of the referral in a timely manner.

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.

- The practice had a mission statement which staff knew and understood the values.
- The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. The governance structure clearly identified the corporate responsibility of the partners to deliver the practice strategy and values. It also identified partners lead roles in both general management and clinical management of the practice. The structures and procedures in place ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained through monthly monitoring using a set of 36 key performance indicators.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were appropriate arrangements in place for identifying, recording and managing risks, issues and implementing mitigating actions. Environmental risks were closely monitored by the practice manager undertaking monthly checks of the premises and equipment.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to them.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected patients reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings and we reviewed a sample of meeting minutes that confirmed this.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met annually and were in regular contact with the practice manager. Contact with a wider group of patients was maintained through a virtual group whereby e-mail communications were exchanged. The three members of the PPG we met gave us examples of the PPG's focus on health promotion and disease prevention. This

Are services well-led?

Good

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

included the practice purchasing self monitoring blood pressure machines in response to patient feedback that these were required. We noted that the PPG had made recent contact with the practice with a view to further expanding their role in supporting developments in health promotion activities.

- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run for example in response to staff feedback the practice had adjusted the recall procedure for undertaking health checks for patients diagnosed with a learning disability. Nursing staff had identified that recalling these patients on the anniversary of their birthdays had increased uptake of the health checks.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

- The practice was working with others in the New Forest area to develop a shared single patient record. This was due to be extended into a local hospice and the community hospital. Information about patient's treatments and conditions was therefore available to a variety of healthcare organisations in the New Forest area. The record enabled prompt sharing of any new diagnosis with all parties involved in the care of the patient.
- One of the GPs specialised in care of the frail elderly which was relevant to the higher than average number of elderly patients registered with the practice. They worked regularly with two consultant specialists in this area of medicine to continually develop their skills and enhance the care available to this group of patients.
- Involvement in pilot schemes and projects was demonstrated for example, e-consultations and attached staff such as the care navigator and clinical pharmacist. New ways of working were always considered and evaluated to identify whether they offered improved, enhanced or expanded services for patients.