Brookside Health Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Requires improvement
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 Brookside Health Centre, Queens Road,

Freshwater, Isle of Wight, PO40 9DT on 4 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing, safe, caring, responsive and well –led services. It was also good for providing services for 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 and people experiencing poor mental health (including people with dementia). It required improvement for providing effective services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- The practice had responded to difficulties in recruiting GPs, by employing Advanced Nurse Practitioners. This meant that the appointments system being used provided more flexibility for patients to make appointments that suited them.

Summary of findings

- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

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

Importantly the provider must :

- Maintain records relating to the management of regulated activities. This means anything relevant to the planning and delivery of care and treatment. To include governance arrangements such as clinical governance, policies and procedures, service and maintenance records, audits, and reviews, purchasing, actions plans in response to risk and incidents. We saw that policies required updating and in one case there was no policy in relation the Disclosure and Barring service checking.

The provider should:

- Ensure that there is a process for good governance at the practice in particular to assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity this should include the quality of the experience of patients in receiving those services.
- Ensure that information about Health and Safety is up to date, accurate and properly analysed. There was a health and safety policy but this had not been updated reviewed since 2013.
- Have effective leadership communication systems to ensure that people who use the service and relevant staff within the practice know the results of reviews about the quality and safety of the service and any actions being taken. We saw that the practice held clinical meetings but practice staff meetings had not taken place for several months.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There was enough staff to keep patients safe.

Are services effective?

Requires improvement

The practice is rated as requires improvement for providing effective services, as there are areas where improvements should be made. Data showed patient outcomes were at or below average for the locality. There was little evidence of completed clinical audit cycles or that audit was driving improvement in performance to improve patient outcomes. Multidisciplinary working was taking place but was generally informal and record keeping was limited or absent.

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 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 also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and a strategy but not all staff was aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management but at times they weren't sure who to approach with issues. The practice had a number of policies and procedures to govern activity, but some of these were overdue a review. The practice proactively sought feedback from patients and had an active patient participation group. We saw that staff meetings and events had not taken place on a regular basis.

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. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

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. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 reflected the needs for this age group.

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. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability at either the practice or at the patient's home, depending on what was most appropriate for the patient. The practice tried to maintain continuity of care with the same team members building up trusting relationships with patients. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 74.59% of people experiencing poor mental health had received an annual physical health check.

The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. longer appointments were available for patients who had poor mental health together with additional health problems.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 24 completed patient comment cards and spoke with five patients at the time of our inspection visit.

Of the 29 people who provided feedback one said they were concerned about speaking with a GP on the phone and felt that the GP should always see the patient and one patient felt that the surgery was no longer a service for patients but a business.

The majority of the comments were very positive about the practice as a whole and patients reported that all the staff were caring and helpful, and treated patients with dignity and respect.

There was a patient participation group (PPG) in place and this group supported the practice with their surveys. Requests for volunteers to join the PPG were advertised through the practice website, the practice leaflet and on posters displayed in the waiting area.

Patients we spoke with and who completed comment cards were extremely positive about the care and treatment provided by the GPs and nurses and the assistance provided by other members of the practice team. They told us that they were treated with dignity and respect and some commented that the care provided was exceptional.

Areas for improvement

Action the service MUST take to improve

• Maintain records relating to the management of regulated activities. This means anything relevant to the planning and delivery of care and treatment. To include governance arrangements such as clinical governance, policies and procedures, service and maintenance records, audits, and reviews, purchasing, actions plans in response to risk and incidents. We saw that policies required updating and in one case there was no policy in relation the Disclosure and Barring service checking.

Action the service SHOULD take to improve

• Ensure that there is a process for good governance at the practice in particular to assess, monitor and improve the quality and safety of the services provided in carrying on of the regulated activity this should include the quality of the experience of patients in receiving those services.

• Ensure that information about Health and Safety is up to date, accurate and properly analysed. There was a health and safety policy but this had not been updated reviewed since 2013.

• Have effective leadership communication systems to ensure that people who use the service and relevant staff within the practice know the results of reviews about the quality and safety of the service and any actions being taken. We saw that the practice held clinical meetings but practice staff meetings had not taken place for several months.

Brookside 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 advisor and a practice manager specialist advisor.

Background to Brookside Health Centre

Brookside Health Centre, Queens Road, Freshwater, Isle of Wight, PO40 9DT is part of the West Wight Medical Practice and has a branch at Yarmouth Surgery, Station Road, Yarmouth, IOW, PO41 0QP. We did not inspect the branch practice.

The practice is responsible for providing primary care services to approximately 10,700 patients covering a large rural area of the Isle of Wight. The majority of the population come from Freshwater, Freshwater Bay, Alum Bay, Totland, Yarmouth and smaller surrounding villages. The practice has a GMS contract with the local clinical commissioning group to provide primary medical services to the area.

The appointments system is designed to provide patients with advice or an appointment as quickly as possible. When patients contact the practice the receptionist will either book an appointment with a GP, advanced nurse practitioner (ANP), nurse or healthcare assistant, or arrange a call back if a patient feels that is what is needed.

For routine matters patients are asked to contact the practice either by telephone or by walking into reception between 8.30am and 3.00pm (Monday to Friday). The reception switchboard is open until 6.00pm.

When a patient requests a call back, the receptionist will take a telephone number where the patient can be contacted by the GP or other Healthcare Professional within a range of times suitable to the patient. Patients are asked to advise the receptionist if the problem is urgent or if the patient has a disability that prohibits them from using the telephone.

Patients are told that it may be appropriate for advice to be given by the GP over the phone, for the patient to see another healthcare professional or have tests before being seen. If an appointment is needed this will be arranged by the patient and the GP. The practice aims to see all patients within 48 hours or at another time suitable to the patient.

At times when a patient's usual GP is away from the practice or on holiday and if the patient agrees that the matter is not urgent and for continuity of care, patients are asked to contact the practice on their GP's return.

If the matter cannot wait until the usual GP is available, the patient is asked to see or speak to another GP.

The practice has opted out of providing out-of-hours services to their own patients and refers them to the Beacon Centre who are the out-of-hours provider on the Isle of Wight. Patients can access the Beacon Centre via the 111 service.

The practice has four GP partners, two managing partners, one salaried GP and three Advance Nurse Practitioners (ANP) who together work the equivalent of seven and a quarter full time staff. In total there were four male and one female GPs. The GPs and ANPs are supported by 11 nursing

staff and health care assistants. The practice also has an administration team of 19 which consists of receptionists, administrators, a secretary, reception manager, IT manager and the practice manager.

The practice has a high number of patients who aged between 55 and 85 when compared to the England average.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with patients who used the practice. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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 whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record

The GPs worked closely with the practice manager on governance at the practice and monitored incidents, near misses and significant events. The practice GPs met on a regular basis to discuss safety of patients and safe care of patients. Any learning points were discussed openly and any actions were taken and systems changes were made where appropriate.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners' meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where systems within the practice had been changed to minimise further risks. For example a pharmacy had requested a prescription for a patient but this was not at the request of the patient and the practice identified that that the patient's medicine had been stopped. This was a repeat incident despite the pharmacy having been given an up to date medicine list. A GP from the practice phoned the pharmacy to ensure that the medicine had been removed from patient records and to make sure that medicine had not already been issued.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding was booked to go on a level three training course and another of the GP's had already taken part in level three training in the subject.

Staff we spoke with were clear about their responsibilities to report any concerns they may have. Staff gave examples of safeguarding, when they would have had concerns and how they would deal with those concerns. Any case of concern was discussed during the clinical meetings.

Staff were also aware of the practice "whistleblowing" policy and understood it.

The practice offered patients the services of a chaperone during examinations if required. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Staff told that this service was offered to patients and performed by nurses.

Medicines Management

Arrangements were in place in relation to the management of medicines at the practice. These included safe storage, records and disposal.

The practice maintained a log of daily fridge temperature checks. Staff were aware of protocols to follow if the fridge temperature was not maintained at the optimum temperature. We saw that the medicines cupboard and the vaccines refrigerator in the nurses' treatment rooms were securely locked. Although there was some confusion over the resetting of the fridge temperature recorders, this matter was addressed and corrected while we were at the practice.

We checked the emergency medicines and found that all the medicines were in date. There was a log maintained with the expiry dates of all the medicines available in the kit. The vaccinations were stored in suitable fridges at the practice. All the medicines and vaccines that we checked were within their expiry date.

There was a GP lead for prescribing and regular audits and reviews of the prescriptions of patients with long term conditions was undertaken using the data collection tools on the practice computer systems. Yearly prescription reviews were undertaken.

Prescription pads were securely kept in a locked cupboard within a designated area of the practice. We saw that box numbers were recorded.

Cleanliness and infection control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection. Nurses confirmed that the lead nurse for infection control had been on a training course for this subject and had cascaded the training down to other staff.

Patients commented positively on the standard of cleanliness at the practice. The premises and especially the

Good

Are services safe?

nurses' treatment room appeared clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with well displayed information, a sharps box for the safe disposal of needles and foot pedal operated waste bins. We spoke with one of the nurses who clearly described the procedures in place to maintain a clean and safe working environment.

Hand washing guides were available above all sinks both in clinical and patient areas. There were bacterial soap pump dispensers and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was good segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

The practice contracted cleaning services out to a company and we saw that there were completed regular schedules of areas that had been cleaned. The recommended colour coded cleaning equipment was stored correctly together. Control of Substances Hazardous to Health (COSHH) information was available.

Equipment

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise.

Staff had taken part in emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment were seen.

Staffing and recruitment

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included appropriate references, and where required criminal record checks, such as using the Disclosure and Barring Service. Newly appointed staff received an induction which included an explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

The practice had gone through a challenging time over the last year after three partners felt that the practice was in difficulty and decided to resign. A project group was set up at the practice with two new business partners joining the practice. This provided some stability and the three original partners retracted their resignation. Two new GPs had joined the practice recently, one as a GP partner and one as a salaried GP.

Monitoring safety and responding to risk

Risk assessments had been carried out for health and safety in the practice and emergency procedures were carried out such as fire alarm testing and evacuation procedures. Changes to risk were monitored and responded to as and when required. However there had not been any recent updates to the policies. For example the health and safety folder had not been updated since 2013.

Equipment testing and fire extinguisher testing were up to date. An up to date and resolved accident book was available. Equipment was checked regularly and when sourcing new equipment, required standards were checked.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency drugs and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service. However this plan needed to be updated as contact details and telephone numbers may have changed since it was last updated in 2013.

Staff had taken part in annual emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Requires improvement

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of patients.

The meetings covered various clinical issues, an example seen was in regards to individualising new patient care; all new patients were offered new patient checks. Chronic disease management appointments were offered as appropriate.

The GPs and nursing staff outlined the rationale for their treatment approaches. They were familiar with current best practice guidance by accessing guidelines from NICE and from local commissioners. Information reviewed confirmed that patients were given support to achieve the best health outcome.

The practice offered full nurse led clinics with GP support for patients with diabetes, asthma, leg ulcers, chronic obstructive pulmonary disease and offered memory checks during reviews. The practice had recently reviewed all the clinics to ensure that they were offering the right amount and level of support to all patients with long term conditions.

Management, monitoring and improving outcomes for people

The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. We spoke with the practice manager about audits and were told that there had been audits conducted for the practice by outside companies, one had been conducted on Osteoporosis and another was being planned for Atrial Fibrillation. The practice was unable to provide details of any other audit and were told that the minimal numbers of audits carried out was due to the time pressures placed on the GPs over the previous months. The practice manager told us that the intention was to increase the number of audits as more time was made available with the introduction of new GPs.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 86.6% of the total QOF target in 2014, which was below the national average of 94.2%. Specific examples to demonstrate this included:

• Performance for diabetes related indicators was similar to the national average.

• The percentage of patients with hypertension having regular blood pressure tests was below the national average

• The dementia diagnosis rate was comparable to the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care, for example, by exploring clinical changes for conditions such as diabetes. The practice used the QOF to evidence they had a register of patients aged 18 and over with learning disabilities, had a complete register available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed. Antenatal clinics were run by midwives and any problems were referred to the GPs.

Effective staffing

The practice comprised four GP partners, two managing partners, 1 salaried GP, a practice manager, seven nurses including three advanced nurse practitioners, and 19 administration staff We observed all staff working professionally and there was a friendly atmosphere at the practice. Staff we spoke with told us that the staffing levels were suitable for the size of the service.

There were appropriate arrangements for staff appraisal and the revalidation of GPs. Staff confirmed there were annual appraisal meetings which included a review of performance and forward planning including the identification of learning and development needs. GPs were up to date with their yearly continuing professional

Requires improvement

Are services effective?

(for example, treatment is effective)

development requirements and all either had been revalidated or had a date for revalidation. (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.)

We saw there was a structured induction programme in place for new members of staff and GPs and records confirmed this was used. There were arrangements in place to support learning and professional development. Nursing staff told us how they were responsible for chronic disease management, for example diabetes and asthma. Staff were appropriately qualified and competent to carry out their roles safely and effectively.

Working with colleagues and other services

We found the GPs, nurse practitioners, nurses and health care assistants at the practice worked closely as a team. The practice worked with other agencies and professionals to support continuity of care for patients and ensure care plans were in place for the most vulnerable patients. GPs and nurses attended multi-disciplinary team meetings to ensure information was shared effectively.

The practice worked with associated health professionals including occupational therapists, district nurses and the community mental health team to support the needs of patients.

The practice also worked closely with other practices and had submitted a joint bid for local funding to support work with the over 75 age group. The Isle of Wight was also in the process of setting up a federation of GP practices, primarily to bid on the behalf of the practices for local authority and clinical commission group commissioned services.

Emergency hospital admission rates for the practice were at 16.2% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect.

Information sharing

Where required information was shared in a responsible and comprehensive way. An example seen was that care plans for vulnerable patients were shared and uploaded to the Isle of Wight Out of Hours service computer systems.

Staff we spoke with were able to explain the training they had received about information sharing. An example given was that when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the clinical staff.

There were alerts in the clinical notes of vulnerable patients and information about how the practice was working to actively protect their safety.

Consent to care and treatment

Nurses demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and patients said that they understood about giving consent and did not feel pressured into agreeing to treatment.

GPs and nurses were aware of mental capacity issues and best interest meetings and also deprivation of liberty safeguarding. They were also aware of what to do when it was deemed the patient did not have capacity to consent and the requirements of the Mental Capacity Act 2005. They discussed the matter with the next of kin, carer as well as fellow professionals. An example given was a recent case where a capacity assessment was requested for a patient in a legal dispute.

Patients we spoke with said that the GP or Nurse practitioner explained what treatment they required and why they needed it and asked the patient's permission when treating them. A recent patient survey conducted in 2014 by NHS England showed that 87.6% patients at this practice who responded described that the last time they saw or spoke with a GP; the GP was good or very good at treating them with care and concern.

Health promotion and prevention

There were a number of notices and information leaflets available in the waiting area. These gave information to patients about such things as flu immunisation, dementia, smoking cessation, diabetes clinics, sexual health clinics and immunisation for foreign travel.

Requires improvement

Are services effective?

(for example, treatment is effective)

The practice ensured that, where applicable, people received appropriate support and advice for health promotion. Information available to patients was effective; there was an extensive pin-board on the wall in the waiting room which was tidy, up to date, and contained notices relevant to the practice population.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The 2013-2014 performance for all immunisations was above average for the CCG.

The practice provided a weekly family planning drop in clinic to all patients. This was available after school and work between five and six in the evening.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk. There were signs that asked for patients to respect the privacy of others. The practice had set aside an area for patients to use if they required further privacy to discuss any matter.

Phone calls were answered professionally and with a friendly greeting, confidentiality was maintained as at no time did we hear mentioned any name, diagnosis or treatment.

Patients told us that they were always treated with dignity and respect and that their privacy was always a priority.

Consulting and treatment rooms were situated away from the main waiting area and we saw that doors were closed at all times when patients were with GPs and nursing staff. Conversations between patients and GPs and nurses could not be heard from outside the rooms which protected patient's privacy. All the treatment and consulting rooms contained a curtain around the examination couch which protected patients' privacy.

The practice ensured that the Out of Hours service was aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

All the patients we spoke with and the comment cards completed were complimentary of the staff at the practice and the service received.

Patients told us that they felt listened to and involved in the decisions about the care and treatment. They expressed the view that they were given appropriate information and GPs took time to support and explain their care or treatment. A recent patient survey conducted by NHS England in 2014 showed that 86.7% patients at this practice who responded described that the last time they saw or spoke with a GP; the GP was good or very good at involving them in decisions about their care.

We saw that patients with long-term conditions were involved in their treatment and care plans and in agreeing with them.

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room and on the practice website told patients how to access a number of support groups and organisations.

The practice asked new patients if they were a carer for anyone and this was recorded on their notes. This practice was then able to help the carer to maintain good health and were flexible with appointment times for carers. The practice had a number of patients with learning difficulties and provided annual health checks, either at the surgery or at home, depending on what is most appropriate for the patient. The practice tried to maintain continuity of care with the same team members building up trusting relationships with patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The GPs we spoke with were able to demonstrate that they considered the particular needs of patients who were vulnerable, such as people with long term health conditions, dementia, learning disabilities, poor mental health and older people. For example, longer appointments were available for patients who had poor mental health together with additional health problems.

The practice had, as a result of the number of changes of GPs, made a decision to use advanced nurse practitioners. This meant that more patients were able to obtain same day appointments.

Clear and well organised systems were in place to ensure these vulnerable patient groups were able to access medical screening services such as annual health checks, monitoring long term illnesses, smoking cessation, weight management, immunisation programmes, or cervical screening.

We saw that the practice had been proactive in seeking and responding to patients. The practice had an effective and active patient participation group (PPG) and we saw that information about the PPG was displayed in the reception area. A section of the practice website provided information about patient satisfaction and how it responded to patient needs and suggestions. A PPG member we spoke with told us that the practice was very good at responding to any issues raised. The main complaint had been the triage system, which was changed, with more doctors and advanced nurse practitioners in place.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was a system in place for flagging whether a patient was at risk of abuse or was a carer.

The practice was situated in purpose built premises which were compliant with legal access requirements for disabled patients. All consulting rooms were on the ground floor. There was a door bell for patients with reduced mobility to alert staff to open the main practice door for them.

Staff told us that there was little diversity of ethnicity within their patient population. However they were knowledgeable about language issues and told us about the language line available for people who did not use English as their first language. They also described awareness of culture and ethnicity and understood how to be respectful of patients' views and wishes.

Access to the service

Until the start of 2015 the practice had adopted the Stour Access appointment system which had undergone a number of changes to respond to the needs of the different populations groups using the practice.

The GP would carry out triage and make a decision about who the patient needed to see next. This would be done over the phone. If an appointment was needed, the GP would sort that out there and then. Or the GP may be able to provide care by phone, with no need for face-to-face contact. If a nurse appointment was needed, or a hospital appointment for tests, the GP would arrange this on the phone.

This practice employed three advanced nurse practitioners (ANP). These are nurses who are trained to provide health care promotion and maintenance through the diagnosis and treatment of acute illness and chronic conditions.

For routine matters patients were asked to contact the practice either by telephone or walking in to reception between 8.30am and 3.00pm (Monday to Friday). The reception/switchboard was open until 6.00pm. The practice was open for emergencies 8.00am to 8.30am and 6.00pm until 6.30pm (Monday to Friday).

The receptionist took the patients telephone number where they could be contacted by the GP or ANP within a range of times suitable to the patient. The patient was asked to advise the receptionist if the problem was urgent or if the patient had a disability that prohibited them from using the telephone.

Appropriate advice was then given by the GP or ANP over the phone, for the patient to see another healthcare professional or have tests before being seen. If an appointment was needed this was be arranged by the patient and the GP or ANP. The practice aimed to see the patient within 48 hours or at another time suitable to the patient.

Good

Are services responsive to people's needs?

(for example, to feedback?)

At times the patient's usual GP may be away from the practice or on holiday. If the patient agreed that the matter was not urgent and for continuity of care, the patient was asked to contact the practice on the GP return.

If the matter could not wait until the usual GP was available, the patient was contacted by another GP.

Brookside Health Centre offered appointments for patients on some evenings and some Saturday mornings. These were arranged with the patients' usual GP.

Home visits due to illness or being housebound, were booked by telephone. Patients were asked to help GPs and to plan efficiently and make requests before 10am, giving some indication of urgency.

The practice had opted out of providing out-of-hours services to their own patients and refers them to the Beacon Centre which is the out-of-hours provider on the Isle of Wight. Patients could access the Beacon Centre via the 111 service.

Listening and learning from concerns and complaints

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

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. The procedure reflected the requirements of the NHS complaints process and included the details of external bodies for complainants to contact if they preferred. For example, the Care Quality Commission and the NHS England ombudsman. This process was included in the practice information leaflet and on the practice website for patients.

We saw a complaints log and asked to see a random selection of complaints. All of these showed that they had been investigated and resolved to a satisfactory outcome.

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

Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care. The practice had a vision and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to patients. Staff said that there was a caring ethos of putting patients first.

Staff said the practice had an open way of working to ensure that everybody felt part of the team. In our discussions with staff some said that due to the number of changes in the structure of the practice they felt that effective communication had suffered in that they were not always sure of what was happening and sometimes felt left out of discussions.

Governance arrangements

We saw good working relationships amongst staff and an ethos of team working. Partner GPs and the salaried GP had areas of responsibility, such as infection control or safeguarding. It was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards.

We reviewed a number of policies, for example, complaints handling protocol and recruitment policy in place to support staff. Staff told us they knew where to find these policies if required. However we found that policies had not been updated regularly for example the business continuity plan had not updated contact numbers and locations since 2013 and although all clinicians had an enhanced Disclosure and Barring Service (DBS) check, we were unable to see a policy or risk assessments in relation to DBS checking for staff in non-clinical roles.

Leadership, openness and transparency

The practice had gone through a challenging time over the last year after three partners felt that the practice was in difficulty. A project group was set up at the practice with two new business partners joining the practice. This provided some stability and two new GPs had joined the practice recently, one as a GP partner and one as a salaried GP.

We spoke with seven members of staff about their own roles and responsibilities; they were not always clear about the new ways the practice worked. They all told us that felt valued, supported and knew who to go to in the practice with any concerns.

We were told that practice meetings had not taken place for some time but we saw that there had been clinical meetings, management meetings and nurse meetings. Staff told us they would give feedback and discuss any concerns or issues with colleagues and management; however we saw that practice meetings had not taken place recently and the last one we saw was recorded as September 2014.

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

There was evidence that the practice had gathered feedback from patients such as through patient surveys and comment cards.

The practice had a patient participation group and the practice worked with them to help improve the care services for patients. This group had recently elected a new chairperson and when we spoke with them they confirmed that the practice was undergoing a lot of changes and were working to improve services.

Patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning and improvement

The practice undertook and participated in a minimal number of audits. We saw that recently incidents had been reported promptly and analysed. We noted examples of learning from incidents and noted that where applicable practices and protocols had been amended accordingly.

We found that this practice had over the past year had to adapt to a great number of changes to staff. They had a new practice manager and managing partners and had lost several key members of clinical staff.

Are services well-led?

Good

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

The GP partners and managing partners said they were committed to working to keep a high level of patient service as well as dealing with the challenges of putting a new team together and the embedding of training and knowledge.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 20 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010. Which corresponds to Regulation 17(2) (d) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 (Part3). This regulation was not being met as the provider had not maintained records relating to the management of regulated activities meaning anything relevant to the planning and delivery of care and treatment. This included governance arrangements such as policies and procedures. Policies required updating and in one case there was no policy in relation the Disclosure and Barring service checking. The practice also had completed a minimal number of clinical audits and therefore not driving improvement in performance to improve patient outcomes. This was a breach of Regulation 17(2) (d) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.