The Gratton Surgery

Quality Report

Gratton Close
Sutton Scotney
Winchester
SO21 3LE
Tel: 01962 760394
Website: www.grattonsurgery.nhs.uk

Date of inspection visit: 16 October 2014
Date of publication: 05/02/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

This was a comprehensive inspection of the Gratton Surgery and was carried out on 16 October 2014.

The practice was well led by the GP partners and the practice manager and provided training opportunities for GP trainees. We rated this practice as good overall.

Our key findings were as follows:

- The practice was rated highly by patients. 90% of patients who respondent to the GP patient survey described the overall experience of the practice as good or very good.
- The practice provided GP appointments at times that met the needs of their patients.
- There were effective infection control procedures in place and the practice building appeared clean and tidy.
- The practice had its own dispensary for patients who lived more than 1.6 km from a pharmacy.

We saw areas of outstanding practice including:

- Patients had the opportunity to speak directly by telephone with their GP each morning between 8.15 and 8.50 a.m.
- The practice had emergency home visit medicines bags containing pre-labelled packs of medicines to ensure that patients had immediate access to the medicines they may need.
- The practice had a system for recording “hospital only” and “over the counter” medicines within the prescribing system to identify any possible drug interactions.
- The practice was able to deal with minor injuries to prevent the need for patients to visit accident and emergency (A & E) or the minor injuries department at the local hospital. The practice nurses were available and trained to suture and dress wounds.

Summary of findings

- The practice had completed an audit of recent deaths. The purpose of this was to identify if all was being done to ensure patients had good end of life care.

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

Importantly, the provider must:

- Ensure that medicines for remote collection that also require refrigeration are kept within recommended temperature ranges.
- Ensure all prescriptions are signed by a GP prior to medicines being handed to the patient.

In addition the provider should:

- Have a risk assessment and policy for the management and testing of Legionella

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

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

There was evidence of the safe management and auditing of infection control within a clean and well maintained building. Arrangements were in place to deal with emergencies and major incidents. Staff were trained and there was appropriate equipment and medicines available to deal with a medical emergency. A detailed business continuity plan was in place to deal with any event which may cause disruption to the service. There were enough staff to keep people safe. However improvements were needed to the systems and processes in relation to the safe management of medicines. For example medicines for remote collection that also require refrigeration and systems to ensure that repeat prescriptions are signed prior to medicines being handed to the patient.

Are services effective?

Good

The practice is rated as good for effective. Data showed patient outcomes were at or above average for the locality. National Institute for Health and Care Excellence guidance was referenced and used routinely. Patients' needs are assessed and care was planned and delivered in line with current legislation. This included health screening, health checks and the promotion of good health. Patients were supported to manage their own health. The practice completed appraisals and the personal development plans for staff. Staff received the necessary support, training and development for their role and extended duties. The practice worked with other healthcare professionals for the benefit of their patients.

Are services caring?

Good

The practice is rated as good for caring. Patients were complimentary about the caring compassionate attitude of staff. They said they were treated with dignity and respect and were involved in care and treatment decisions. Staff gave patients the information they required about their treatment to ensure they were able to make informed choices.

Staff provided privacy during all consultations and reception staff maintained patient confidentiality when registering or booking in patients.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the clinical commissioning group to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. Clear details of the appointment system were available in the practice brochure and on the practice website. Patients were able to telephone the practice and speak directly to their GP each morning. There were sufficient numbers of GPs available to ensure that any patient who felt they need to see a GP could do so.

The practice and was equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a vision to continue to provide good quality health care, to increase patient numbers and the services they could offer. Staff were aware of the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the GPs and practice management. The practice had an established staff team and a culture of openness and honesty was encouraged. The quality, performance and effectiveness of the service were monitored. The practice had a number of policies and procedures to govern activity and regular governance meetings took place. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and this had been acted upon. Staff had received regular performance reviews and attended staff meetings.

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 the practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet patients' needs and had a range of enhanced services, for example end of life care. There was good communication with other health care providers to ensure the needs of these patients was met. For example the practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.

The practice was responsive to the needs of older people, including offering home visits. The practice had a number of older patients who lived in care homes and the GP visited them at the homes as needed. In addition the GPs used these visits to speak with or monitor the health of any of their other patients who lived in the same care home. Each patient over 75 years of age had a named GP and were able to see any GP of their choice for continuity of care when necessary or specialised care and treatment if needed.

Patients benefitted from the option of receiving medicines from the dispensary in monitored dosage systems.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice was aware of those patients with long term conditions and had processes in place to make urgent referrals to secondary care should it be necessary or when needed longer appointments or home visits were needed. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the patient's GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Administration staff were responsible for tracking certain streams of information such as asthma and chronic obstructive pulmonary disease (COPD) and inviting patients into the practice for health checks.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. The practice had identified that young families found access to their branch surgery more convenient and

had organised services for that population group to be concentrated at those premises. Patients told us that the GPs communicated well to provide continuity of care with the midwifery and health visiting team who held clinics at the practice.

Immunisation rates high for all standard childhood immunisations in relation to other practices in the area. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals.

Appointments were available outside school hours and the practice was suitable for children and babies. Urgent treatment was given to children and staff reacted swiftly to identify common factors that may mitigate risks to other children.

Staff knew how to recognise signs of abuse in children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the 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, for example appointments could be booked and repeat prescriptions requested via the practice web page. Health promotion and information in relation to health screening was available which reflected the needs of this group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients with learning disabilities and GPs told us they had a personal knowledge of all patients with a learning disability. The practice had carried out annual health checks for patients with learning disabilities.

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

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. The practice had in place advance care planning for patients with dementia. The practice's multidisciplinary meetings included representatives from the older person's mental health team.

Patients experiencing poor mental health had a named GP for continuity of care The practice had sign-posted patients experiencing poor mental health to resources such as online cognitive behaviour therapies. Practice staff had received a recent mental health update as part of their Wessex educational trust accreditation scheme.

Summary of findings

What people who use the service say

We spoke with 10 patients on the day of our inspection. We reviewed seven comment cards which had been completed by patients in the two weeks leading up to our inspection.

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

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

Patients told us that staff had a caring attitude and they felt safe with the care they received. Patients were satisfied with the appointment system and the ability to get appointments to suit their needs. Patients said that they appreciated being able to speak with their GP by telephone, although this often meant having to wait on the telephone line for a considerable amount of time for their GP to become available. There was an online booking system for appointments and the option of seeing a GP at the nearby branch surgery, which was convenient for some of the patients we spoke with. Patients commented positively on the ability to collect their prescriptions from the practice dispensary or from shops in the neighbouring villages.

There had been 257 responses to the patient participation group survey that the practice had conducted between December 2013 and January 2014. This survey showed that 90% of the patients who responded to the question about their experience of the practice rated it as good, very good or excellent. The practice was rated highly by patients for the care and concern they were shown, their confidence in the ability of the GP or nurse and their ability to listen.

Areas for improvement

Action the service MUST take to improve

- The practice must ensure that medicines for remote collection that also require refrigeration are kept within recommended temperature ranges.
- The practice must ensure all prescriptions are signed by a GP prior to medicines being handed to the patient.

Action the service SHOULD take to improve

- The practice should have a risk assessment and policy for the management and testing of Legionella.

Outstanding practice

- Patients had the opportunity to speak directly by telephone with their GP each morning between 8.15 and 8.50 a.m.
- The practice had emergency home visit medicines bags containing pre-labelled packs of medicines to ensure that patients had immediate access to the medicines they may need.
- The practice had a system for recording "hospital only" and "over the counter" medicines within the prescribing system to identify any possible drug interactions.

Summary of findings

- The practice was able to deal with minor injuries to prevent the need for patients to visit accident and emergency (A & E) or the minor injuries department at the local hospital. The practice nurses were available and trained to suture and dress wounds.
- The practice had completed an audit of recent deaths. The purpose of this was to identify if all was being done to ensure patients had good end of life care.

The Gratton Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a specialist advisor in practice management.

Background to The Gratton Surgery

The Gratton Surgery is located in Gratton Close in the village of Sutton Scotney, near Winchester Hampshire. The practice is operated from purpose built premises which are owned by the GP partners. The practice building has seven consulting rooms, two treatment rooms and a dispensary. There is space for allied clinical services to use the consulting rooms. On occasions other health care professionals use the premises. The community nursing team have permanent office facilities in the building.

The Gratton Surgery has a branch surgery in Downs Road, South Wonston, near Winchester. A neighbouring village approximately three miles away. We did not inspect the service offered from the South Wonston branch surgery.

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

The practice provides a range of primary medical services to approximately 6,700 patients. Patients are supported by, two male and two female, GP partners and two female salaried GPs. At the time of our inspection the two female GP partners' roles were being temporarily covered by a female locum GP. The practice provides 34 GP sessions per week. Further support is provided by a practice manager, two practice nurses, a health care assistant and administrative and reception staff. The practice is a training practice and has a GP registrar working at the practice. (A GP registrar has completed their medical training to be a doctor but needs to complete another year in primary care to specialise as a GP).The practice is a member of the West Hampshire Clinical Commissioning Group (CCG).

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

West Hampshire CCG covers a significantly less deprived area than the average for England. The Gratton Surgery covers an area equal to the least deprived 10% of England.

Why we carried out this inspection

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

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

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

Detailed findings

How we carried out this inspection

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

We carried out an announced visit on 16 October 2014. During our visit we spoke with a range of staff including some of the GPs working that day, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed seven comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

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

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

The Gratton Surgery has a low percentage of their patients in the 15 to 34 age group compared with the average for England. The percentage of patients between the ages of 45 and 69 registered with this practice is higher than the average for England. The practice population ratio is slightly higher female to male.

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke to were aware of their responsibilities to report incidents and near misses. For example when an incorrect referral had been made to hospital care this had been reported and investigated to ensure that another patient had been referred appropriately and that the two week time frame had not been exceeded.

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

Medicines recalls were received in the dispensary via two separate communication routes and acted on by dispensary staff, who also recorded the actions taken.

Learning and improvement from safety incidents

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

Time was allocated to significant events on the monthly clinical leads meeting agenda and this provided staff with the opportunity to discuss any incident and to record any actions. There was an annual report of all significant events which was discussed along with a review of complaints at a practice meeting which was open to all staff. There was evidence that changes were made to practice as a result of incidents and complaints and those findings were disseminated to relevant staff verbally or through departmental or full staff meetings. Systems within the practice had been changed to minimise future risks.

We saw minutes of meetings, where significant events had been discussed, and the annual summary of significant events. However these were not clear about the learning from these events. Actions to minimise future risk had been recorded but it was not always easy to identify the learning points. Staff including receptionists, administrators, nursing and dispensary staff were aware of the system for raising issues and felt encouraged to do so.

We saw incident and significant events forms were available. Once completed these were sent to the practice manager who showed us the system they used to oversee manage and monitor them. Evidence of action taken as a result was shown to us. A number of reported dispensing errors had resulted in the practice employing more dispensary staff to reduce workload related errors

National patient safety alerts were disseminated by the senior partner to practice staff by email and the electronic messaging system. Staff told us alerts were discussed at the appropriate practice meeting.

Reliable safety systems and processes including safeguarding

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as social services.

All staff had received relevant training on safeguarding. The provider's training records were made available to us and showed that all staff had received training in safeguarding which, we were told, covered safeguarding children and vulnerable adults. The GP who took the lead for safeguarding and their deputy had completed level three training for children's safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. Staff knew how to access the practice safeguarding policy, knew which GP look the lead for safeguarding and who to speak to in the practice if they had a safeguarding concern. However contact details for local authority safeguarding contacts were not readily accessible to all staff.

Are services safe?

There was a system to highlight vulnerable patients on the practice's electronic records, for example all people in the family of a vulnerable child had easily seen alerts on the electronic system. This would alert staff to any concerns that may put the child at further risk.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who accompanies another person during treatment or examination). Nursing staff or GPs acted as chaperones when required.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic software system for primary healthcare, which collated all communications about the patient including scanned copies of communications from hospitals.

Medicines management

We checked medicines stored in the dispensary and medicine refrigerators and found they were stored securely, however the refrigerator keys were not kept secure when not required. This was resolved when we raised our concerns with staff during the inspection. Practice staff monitored the refrigerator storage temperatures and appropriate actions were taken when the temperatures were outside the recommended ranges. Staff had identified the dispensary area may feel hot however the room temperature was not monitored to reduce any risks.

Processes were in place to check medicines were within their expiry date and suitable for use including expiry date checking and rotating short dated stock.

The practice had identified an increase in dispensing errors; these were investigated as individual incidents and as a cluster. The practice made a number of changes which improved the situation.

Vaccines were administered by nurses using patient group directions that had been produced in line with national guidance and we saw up to date copies. There were also appropriate arrangements in place for the nurses to administer medicines that had been prescribed and dispensed for patients including administration protocols.

Staff explained how the repeat prescribing system was operated. For example, how staff generated prescriptions and monitored for over and under use and how changes to patients' repeat medicines were managed. There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. The practice had a system for recording medicines prescribed by others for example "hospital only" or purchased over the counter which was linked to their prescribing system and therefore provided a prescribing overview.

The dispensary staff explained how repeat prescription requests were managed; those within the review date or number of permitted repeats would be generated. Whilst, if a review date or number of permitted repeats were exceeded; this would be escalated to a GP via the practice computer system and the GP would take appropriate actions. All prescriptions, for non-dispensing patients and for controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse), were reviewed and signed by a GP before they were given to the patient. If a GP prescribed medicines during a consultation for a dispensing patient, these prescriptions were authorised by the GP via the computer system, printed in the dispensary and dispensed, then signed by the GP at the end of the clinic session. When dispensing patients or their representative requested non-controlled drug medicines on repeat prescription, dispensary staff would generate and dispense these prescriptions. These prescriptions were not authorised by the GP until after the patient had collected the medicines.

Blank hand written prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had a system in place to assess the quality of the dispensing process

The practice held stocks of controlled drugs. For example, controlled drugs were stored in a controlled drugs safe, access to them was restricted and the keys including the spare keys were held securely. Whilst records were kept of who had collected the controlled drugs some of these signatures were not person identifiable. There were arrangements in place for the destruction of controlled drugs.

The practice had established a service for patients to pick up their dispensed prescriptions at three locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure patients collecting medicines from these locations were

given all the relevant information they required. Medicines requiring refrigeration were not monitored for the temperature to be in safe parameters during delivery to the pickup or at the pickup point.

Cleanliness and infection control

The practice had a lead for infection control procedures at the practice, the lead nurse had undertaken training in February 2013 and September 2014 for this role, to enable them to provide advice on the practice infection control policy and carry out staff training. We saw training records which showed that all practice and dispensary staff had received an infection control update in October 2014. There were appropriate policies and procedures in place to reduce the risk and spread of infection. Infection control procedures had been subject to an annual audit.

We saw a copy of a complete audit and one that was in progress. The completed audit was not dated but we were told it had been carried out approximately six months ago. We saw that shortfalls had been identified although there was no formal recorded action plan. Following the most recent audit we found that improvements had been completed. For example posters giving hand washing instructions were available at all sinks.

We observed the premises to be clean and tidy. We noted that the infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures and to comply with relevant legislation. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Any occupational health issues for staff were met by a neighbouring practice. One of the GP partners had specific training in occupational health. Staff had been referred for pre-employment checks on immunisation and Hepatitis B status. The practice checked the Hepatitis B status of all their GPs and nurses every five years.

The practice did not have a policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular flushing of their water system to minimise the risk of Legionella and reduce the risk of infection to staff and patients. The practice did not have a record available of any water tests or a risk assessment in relation to Legionella.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises were visibly clean and well maintained. Work surfaces could be cleaned easily and were clutter free.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that medical equipment had been calibrated in July 2014, there had been no action necessary at that time as all equipment was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) in November 2013 and were deemed safe to use.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting GPs and nurses and non-clinical staff. However this policy did not give clear guidance about the information that should be available, to ensure the person was of good character and had the required qualifications or skills. We saw that there was a risk assessment for each member of staff as to whether a DBS check was required for their role. Reference to DBS checks was not included in the recruitment policy.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a system in place for the different staffing groups to ensure there were enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave.

The GP session to patient ratio at this practice was higher than average for England. Locum GPs provided cover for GP absences. Staff told us this was usually covered by a GP

Are services safe?

who was known to the practice. Patients did not report any difficulty in accessing a GP consultation. This was confirmed by the reception staff who had not experienced difficulty meeting patients' needs for GP consultations.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and six monthly checks of the building, the environment and emergency alarms. There was a quarterly plan for the risk assessment and hazard identification of various aspects of the service. The practice also had a health and safety policy and there was an identified health and safety representative.

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

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being. The practice held regular multi-disciplinary meetings where patient needs were discussed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records to show that all staff had received training in resuscitation and there was a system in place to ensure GPs and nurses repeated this training at least every 18 months and other staff at least every three years. All staff asked, knew the location of the automatic external defibrillator (AED) a machine which is used in the emergency treatment of a patient suffering a cardiac arrest, oxygen, and emergency medicines. We were told that emergency equipment was always taken to the branch surgery when GPs were working there.

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. Processes were in place to check emergency medicines were within their expiry date and suitable for use. The practice nurse ensured the equipment was working and the medicines were in date to ensure they would be safe to use should an emergency arise.

Emergency medicines and medicines for home visits including pre-labelled packs were available in a secure area of the practice and all staff knew of their location. Medicines were for the treatment of cardiac arrest and other medical emergencies. The batch numbers and expiry dates were recorded on the emergency bag check sheets however some of the medicines had been cut from their original packaging and we were unable, in some cases, to identify batch and expiry dates. Therefore the practice could not check the expiry dates and confirm with the record on the check sheets.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The practice had established relationships, and formal arrangements were in place with neighbouring practices to ensure that patient care could continue in an emergency.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs were able to describe how they accessed guidelines from both the National Institute for Health and Care Excellence (NICE) and from West Hampshire Clinical Commissioning Group (CCG).

We saw minutes of meetings where new guidelines were disseminated and patients were discussed. For example the change in NICE guidelines in relation to patients with atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate). An audit of the practice's patients in this group had been carried out and a decision made to invite those whose medicines fell outside the guidelines to attend the practice to discuss their medication.

Whilst there was no formal policy for ensuring GPs and nurses remained up-to-date the practice manager kept a log of training in subjects such as infection control, safeguarding and resuscitation. There was also a record available of all the training courses each member of staff had attended. The Gratton Surgery is a training practice for GP registrars and there was a plan of outside speakers or internal presentations documented in the education schedule. Subjects reflected the personal development plans of the practice GPs. All the GPs and nurses interviewed were aware of their professional responsibilities to maintain their professional knowledge.

GPs had areas of special interest such as palliative care, dermatology and wound care. GPs and nurses were very open about asking for and providing colleagues with advice and support. GPs told us they continually reviewed and discussed new best practice guidelines for the effective management of their patients' conditions. We saw that new guidelines were disseminated and the implications for the practice's performance and patients were discussed at clinical meetings and any required actions agreed. The GPs and nursing staff told us they were familiar with current best practice guidance and accessed guidelines from NICE and from local commissioners.

The practice referred patients appropriately to secondary and other community care services. National data showed the practice is in line with national standards on referral rates for all conditions. The practice had responded to a CCG referral audit by conducting their own referral audit. This had identified the high rate of ear, nose and throat (ENT) referrals. This had prompted the practice to arrange for an ENT surgeon to provide an education session to discuss appropriate referrals with the practice GPs. We found that elective and urgent referrals to secondary care were not routinely reviewed or discussed between the practice GPs apart from referrals made by registrars which were monitored as part of their training.

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

The practice ran a number of specialised clinics to meet the needs of patients. These included asthma and chronic obstructive pulmonary disease (COPD) clinics and a diabetic clinic run by a practice nurse who had a specialist qualification in diabetic care. The diabetic clinics were organised to ensure patients were seen twice a year as a minimum. The practice nurse had prepared packs for each patient with relevant guidance and educational material. Patients newly diagnosed as diabetics were identified by the practice to ensure they received related health checks carried out by the practice nurse with support from the GPs.

The practice was aware of the top 2% of their patients at most risk of frequent hospital admission. Care plans had been produced for each of these patients. The practice had made a successful transformation fund bid to work with two neighbouring practices to identify the next 2% of their patients at risk. Safety packs had been made available in the homes of patients who had been assessed as needing end of life care in order to minimise the need for hospital admission.

Management, monitoring and improving outcomes for people

The practice has a system in place for completing clinical audit cycles. For example we saw an audit regarding the prescribing of anticonvulsant medicines and a first cycle

Are services effective?

(for example, treatment is effective)

audit of the use of aspirin for patients with atrial fibrillation. Following the audit the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. The practice showed us a completed audit cycle on nurse triage the practice was able to show what actions had been taken following the audit and the learning points identified to improve patient care.

GPs at the practice undertook minor surgical procedures in line with their registration and NICE guidance. We saw an example of a clinical audit of their procedures and the findings used to improve practice systems.

The practice routinely collected information about patients' care and outcomes. The Quality and Outcomes Framework (QOF) was used to assess the practice's performance (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries). The practice regularly reviewed their achievements against QOF. The practice had strong links with neighbouring rural practices who they worked with to identify best practice and improve outcomes for their patients. The QOF data was actively monitored at the practice and GPs were made aware of any shortfalls that needed to be addressed. Administration staff were responsible for tracking progress against QOF. QOF data showed the practice performed in line with local practices and was better than average for completing a register of all patients in need of palliative support and the regular multi-disciplinary case review meetings that were held.

The practice GPs told us they all had responsibility for keeping up to date with recent guidance. Updates in guidance from the NICE were discussed at the weekly partners' meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending those courses agreed by the practice as mandatory, such as infection control, safeguarding and resuscitation. A good skill mix was noted amongst the GPs with most having additional qualifications for example in palliative care, occupational health, obstetrics and family planning. Practice nurses had attended training or gained further qualifications in subjects such as asthma care, diabetes, cervical screening and learning disability health checks.

The practice had identified that the service would benefit from two members of the nursing staff undertaking training to qualify as independent prescribers and this was to start shortly. We were told that all members of staff involved in the dispensing process had received appropriate dispensing training and in-house training on final accuracy checking.

The practice had an education schedule and had sourced and delivered training in a range of subjects over the past year in subjects such as cognitive behaviour therapy, allergies, and learning disability health checks.

All the staff we spoke with in both clinical and administrative roles told us they were well supported by the GPs and the practice manager. There was a system of induction in place for newly recruited staff.

There was an annual appraisal system in place for staff. Staff told us they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. Staff told us the practice organised staff training in a number of areas and supported staff to attend relevant training.

GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC). All GPs were aware of their appraisal schedule and revalidation dates. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council). One of the GPs at the practice was a GP appraiser and all the GPs had engaged with the appraisal process. GPs were allowed protected time for this process.

The practice was a training practice, doctors who were in training to be qualified as GPs (registrars) were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from the registrar we spoke with was positive about the help, training and support they had been given.

During our inspection we spoke with ten patients and reviewed seven comment cards. They all commented positively on the availability of appointments and waiting times once they were at the surgery. Although some patients were concerned about how long they sometimes

Are services effective?

(for example, treatment is effective)

had to wait for their telephone calls were answered. The practice had, at the time of inspection, a practice list of 6,700 patients with between 30 and 34 GP sessions available each week, providing above the national average GP consulting time to their patients. There was sufficient staff available to meet their needs.

Working with colleagues and other services

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to use the practice premises or branch surgery to provide services to patients. These included a chiropodist, health visitors, a dietician (for patients referred by the GPs) and the community nursing team. Antenatal and postnatal care was provided by visiting midwives and health visitors at the branch surgery. GPs and nurses worked closely with health visitors, school nurses, the community nursing team, social workers and a palliative care consultant. The practice held weekly partners' meetings. One in four of these was a multidisciplinary meeting which was attended by health care professionals as appropriate.

Where appropriate people with long term conditions were directed to the New Medicines Service.

The community nursing team had a base at the practice. They told us that they had strong links with the practice and worked closely with the GPs and practice nurses. They were in constant contact to discuss patients and their care needs. They told us they felt part of the practice both professionally and socially. The district nursing team was able to access the practice's electronic recording system and could use that to get advice from, or send updates to, the GPs. They told us they were able to get immediate contact with a GP if necessary for help or advice.

There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results, received from other health care providers, for their patients. Administration staff collated information in a variety of formats from the Out of Hours provider or from other organisations. Any information relating to patients was highlighted to the GPs for checking. They were then able to take immediate action if required.

Information sharing

Patient information was stored securely on the practice's electronic record system. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. The practice had historic paper patient records which were used if necessary to review medical histories.

Reception and administration staff had systems in place to add to patient records information that was received from other healthcare providers. We saw that information was transferred to patient records promptly following out of hours or hospital care. One of the patients we spoke with said that transition from hospital care to GP care had been seamless and that their initial referral to hospital had been through choose and book which had been organised efficiently by the practice. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Letters and other documents including discharge summaries, out-patient recommendations and shared care agreements about medicines from the local hospitals, out of hour's providers and the ambulance service were received both electronically and by post.

The weekly clinical meetings had time set aside for information sharing with multidisciplinary input for discussions of complex patients, these meetings were minuted.

The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to Mental Capacity Act 2005 (MCA). We saw the practice had produced a policy document in relation to the MCA and were able to describe how they implemented it in their practice. However staff had not received training specifically in the subject. For a specific scenario where capacity was an issue, the practice had not clearly documented the context for making a best interest's decision. Patients with learning disabilities and those with dementia were supported to make decisions usually with their families. Thought had not always been given to a patient's level of understanding or ability to make informed consent in certain circumstances.

Are services effective?

(for example, treatment is effective)

GPs we spoke with demonstrated a clear understanding of Gillick competencies, to identify children aged under 16 years of age who have the capacity to consent to medical examination and treatment and were familiar with using the assessment.

There was a practice policy for documenting consent for specific interventions. For example, written consent was obtained for all minor surgery and some family planning procedures. For other interventions a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had been followed in 20 of the 21cases reviewed, one person did not have a copy of their written consent scanned into their notes.

Health promotion and prevention

All new patients to the practice were offered a health assessment to ensure the practice was aware of their health needs. The GP was informed of any health concerns identified and these were followed-up in a timely manner. GPs and nurses used their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, by offering smoking cessation advice to smokers or preconception counselling. The health care assistant monitored obesity and diet on request from a GP or practice nurse.

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

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

The practice had a good knowledge of all their patients with a learning disability. These patients were offered a physical health check and all had received a check up in the last 12 months. Two of GPs two practice nurses and the health care assistant had recently completed learning disability annual health check training.to support their patients.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. The practice offered flu vaccinations in line with current national guidance. Patients told us that the practice publicised the vaccinations well and sent a letter to them offering a vaccination for shingles.

The practice had offered quit smoking advice and support to 78% of their identified smokers. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Following recent news of the spread of the Ebola virus the practice had discussed how this could be managed if they suspected a patient had contracted the virus. We noted that information was available for staff to pass on to patients and protective personal equipment packs had been put into each treatment or consulting room.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey, NHS Choices and the practice's own satisfaction survey conducted between November 2013 and January 2014. The evidence from all these sources showed patients were satisfied with how they were treated which was with care, courtesy and professionalism. The practice's satisfaction scores on consultations with doctors and nurses showed that 83% of practice respondents said the GP or nurses were good at listening to them and 71% saying the GP gave them enough time although 25% of respondents felt that question did not apply to them.

Staff told us how they respected patients' confidentiality and privacy. All telephone calls were made and answered by staff who were not sitting at the reception desk. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private and ensured that confidential information could not be overheard. We saw this in operation during our inspection and noted that it was effective in maintaining confidentiality. However one patient used the practice survey to request the dispensary hatch was made more private. Structural changes to the dispensary area had been discussed however the practice had not yet made any arrangements to address this. All staff had taken part in information governance training and those we asked were able to demonstrate how they ensured patients' privacy and confidentiality was maintained.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the practice's satisfaction survey, for those patients for which it was relevant, showed almost all respondents felt the GP explained their treatment well and they were involved in decisions about their care.

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

Patient/carer support to cope emotionally with care and treatment

We saw minutes of recent partners' and clinical meetings. GPs had discussed patient deaths and bereaved families and the support they may need. Patients at risk of hospital admission or needing end of life were discussed at multi-disciplinary meetings when emotional support was discussed with representatives from local hospices and McMillan nurses. GPs offered personal, or arranged district nurse, visits to bereaved families and suggested referrals to national support organisations or local counselling services.

GPs told us that they involved families and carers in end of life care and worked to provide all the help and support for those patients at the end of life. One of the GPs had completed an audit of recent deaths. The purpose of this was to identify if all was being done to ensure patients had a good death. The results of the audit identified learning points including how discussions in relation to 'do not resuscitate' were recorded and how the practice would continue to develop their whiteboard meetings, focussing on appropriate patients. (Whiteboard meetings are

Are services caring?

meetings held between GPs and other healthcare professionals to discuss the complex needs of patients). Two GPs at this practice had a special interest or further qualification in palliative care and two of the GPs worked at local adult and children's hospices.

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs. The out of hours service received specific patient notes. This included individualised information about patient's complex health, social care or end of life needs.

Notices in the patient waiting rooms, on the TV screen and patient website also signposted people to a number of support groups and organisations. The practice recorded if a patient had caring responsibilities. One of the practice nurses had the role of carers' lead to ensure they understood the various avenues of support available to them.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

All patients had a named GP who was responsible for their care. Whenever possible patients were offered the GP of their choice or were directed to the GP who, through a special interest or extended training, was best able to meet their needs. All patients over 75 had a named GP in line with current recommendations. Longer appointments were available for people who needed them and those with long term conditions. Home visits were regularly made to local care homes.

The practice was aware of the practice population in respect of age, ethnic origin and number of patients with long term conditions. The practice had responded to the needs of the practice population. The practice and its branch surgery served a semi-rural community. Services were planned to take into account the needs of the community. The practice had its own dispensary which could be used by all patients apart from those that lived within 1.6 km of another pharmacy. The pharmacy offered a medicines review appointment with one of their trained dispensers. An informal 15 minute discussion to help patients know more about the medicines they were taking, identify any problems they may be experiencing with their medicines and to make sure medicines were taken effectively to prevent unnecessary waste. The dispensary offered a remote collection service which meant that, for those for whom travel to the dispensary was difficult, medicines could be collected from shops in neighbouring villages.

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

The practice had a high percentage of patients of working age. Extended hours opening until 8.15 pm were available alternate Mondays and alternate Saturday morning surgery was available for patients who could not attend during weekdays due to work commitments.

The practice had a large number of patients with diabetes and had introduced a system to ensure they were all seen on a regular basis to monitor their condition and to provide advice and education. A phlebotomist (a person who has been trained to take blood samples) from the local general hospital saw patients at the practice two days each week to take blood samples for patients. This service meant patients did not have to travel long distances to the hospital for any diagnostic blood tests. This service had been implemented following patient feedback from the practice's 2012-2013 survey.

The practice worked collaboratively with West Hampshire Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example the sharing of clinical expertise and to share best practice ideas for improving the service and managing delivery challenges to the practice population.

The practice had a patient reference group (PRG). The practice's patient feedback survey had been designed based on issues raised by the group. The PRG had been consulted about the questions for the annual patient survey carried out between December 2013 and January 2014. Following the survey the PRG had agreed a plan of action with the practice for changes in response to the outcome of the survey. This included a review of the morning phone calls and working with the telephone supplier to improve the information patients heard when dialling in. The practice manager told us that the practice was constantly reviewing the appointment system following feedback from patients.

Tackling inequity and promoting equality

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

The practice provided health checks for their patients who had a learning disability. The practice had a number of older patients who lived in residential care. If these patients required a GP they were visited in their care home. The GPs used these visits to speak with or monitor the health of any other of their patients who lived in the same care home.

Staff had not taken part in training in equality and diversity however they could demonstrate that they promoted equality in the practice.

The premises were purpose built; we saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. However the premises did not allow for independent access for any patient who used a wheelchair or had mobility issues. There was an automatic

Are services responsive to people's needs?

(for example, to feedback?)

main door to the practice building but the next entrance door into reception had to be opened manually and opened outwards. Reception staff showed us a mirror which was positioned in the reception area which allowed them to see if patients needed help with access. An induction loop was available at the reception area to enable people with a hearing impairment to communicate with reception staff. However the reception area was at a high level which could be a barrier to anybody who used a wheelchair. There was access to the ground floor treatment and consultation rooms for these groups of patients. Two of the consulting rooms were on the first floor and there was no lift. Patients with mobility issues were seen in a ground floor consulting room by their GP. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Information relating to the practice opening hours was available on the practice website and in the practice brochure. These gave information for patients on how they could book appointments online, by telephone, or in person and how to organise repeat prescriptions online or at the dispensary. Opening hours were from 8am to 6.30 pm with appointments available from 8.50 am. All GPs were available to speak with their patients by telephone each morning between 8.15 and 8.50am. Nurse led minor illness clinics were also available. Extended hours were available as a minimum two Saturday mornings and two late evening surgeries per month. Reception staff explained the appointment booking system. Patients could telephone the practice or book routine appointments on line. Bookable telephone consultations were also available to enable patients to speak with a GP.

The practice offered patients the opportunity to speak directly to their own GP. Patients could call the practice without an appointment each morning between 8.15 and 8.50 to ask for advice or review their medication. Patients told us that they really appreciated this service but sometimes had to wait in a telephone queue for quite a time on busy days. The practice had responded to feedback from patients and had put in place some bookable telephone slots later in the morning.

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

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

The practice was also able to deal with minor injuries to prevent the need for patients to visit accident and emergency (A & E) or the minor injuries department at the local hospital. The practice nurses were available and trained to suture and dress wounds.

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 there was a designated responsible person who handled all complaints in the practice.

Accessible information was provided to help patients understand the complaints system this was set out in the practice brochure, on the practice website and displayed in the practice. Patients were able to raise their concerns or make a complaint either verbally or in writing to the practice manager or any GP and could request a meeting to discuss their concerns with the practice manager. A comments book was available on the reception desk. We saw that any comments made in the book had been responded to.

We reviewed policies and procedures for complaints and whistleblowing and records of complaints received. We found that the practice responded quickly to issues raised. The record of complaints showed that all complaints had been responded to in a courteous manner by the practice manager. We saw that complaints were discussed at partners' meetings to ensure they had been dealt with

Are services responsive to people's needs?

(for example, to feedback?)

appropriately. However actions and learning points arising from patient complaints had not been promptly recorded.

For example we saw that a complaint received on 4 June 2014 had not had been analysed to ensure that any themes or trends were identified to improve the service patients received as a result of feedback.

Are services well-led?

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

Our findings

Vision and strategy

The practice vision was to provide good quality health care, to increase patient numbers and the services they offered and to develop their staff to benefit patients. The practice brochure contained their mission statement. This stated that all members of dedicated to achieve quality health services, tailored to meet their patients' needs.

We spoke with two GPs, a GP registrar, two practice nurses, the practice manager and a number of reception and administration staff. They were aware of the practice values and their responsibilities in relation to these.

All staff felt able to make suggestions to improve outcomes for patients for example in relation to appointment systems or from personal research or learning. GPs used weekly partners' or clinical meetings and clinical audit to share and discuss information to improve effective patient care.

The practice had made a successful bid to secure funding towards providing continued improved services for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff.

Clinical governance was a regular topic for discussion at weekly partners' meetings. We looked at minutes from meetings. We found that performance, quality and risks were discussed including any incidents involving medicines. The GP partners had three or four away days each year where corporate governance was discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and to monitor the effectiveness of the practice, for example the identification of disease and unplanned hospital admissions. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was discussed at partners' meetings and regularly monitored and reviewed to maintain or improve outcomes.

Clinical audits were regularly undertaken by the practice GPs. We saw evidence of completed audit cycles such as nurse triage and medicines optimisation. A number of first cycle audits were available for example minor surgery and referrals to other services.

The practice manager and GPs demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk that may affect care and service quality.

The dispensary manager told us about a local peer review system they took part in with neighbouring dispensing GP practices. Where they had recently visited other practices to assess the suitability of a bar code checking system for use in the dispensary.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and one of the partners was the clinical lead and the practice's Caldecott Guardian. The weekly clinical meetings were used for GPs to cascade information to colleagues. The GPs had a collective responsibility for making decisions and monitoring the effectiveness of clinical practice through audits or specialist training. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing administration and reception staff.

The leadership was established at the practice as GP partners had been in their roles for a number of years. All the staff we spoke with told us they felt supported by the practice manager and GPs. All staff confirmed there was an open culture and felt that they could question each other about their working practices. Staff we spoke with felt able to talk with any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and that they were provided with opportunities for development and training. Appraisals were carried out annually and training was supported by the GP partners and practice management. We saw that serious events were reported and discussed at weekly GP meetings for assurance that they had been dealt with appropriately and not to apportion blame. However there was not always a learning outcome recorded. For example a recent prescribing error had been discussed and an explanation recorded but it was not detailed what could be done to prevent a similar error occurring again. Staff informed us that communication within teams and across the service was good with information shared appropriately.

Are services well-led?

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the age discrimination policy, disciplinary procedure and the locum policy, which were in place to support staff.

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

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

We looked at the results of the national patient survey. The proportion of respondents to this survey who described the overall experience of their GP surgery as good or very good was over 90%. Areas achieving lower satisfaction scores related to the practice's opening times, although 97% of respondents stated that the last time they wanted to see or speak with a GP or nurse from the practice they had been able to get an appointment. The practice manager and reception staff were able to tell us of the changes to the appointment system that they continued to make to improve this service to patients. We saw that the results of the practices own survey had been analysed and an action plan was in place to address any areas for improvement.

The practice had a patient reference group (PRG) with representatives from all ages of the patient population except those under 16 or over 85 years of age. The practice website invited all patients to join the PRG.

There had been 257 responses to the patient survey which was conducted between December 2013 and January 2014. The survey questions had been developed collaboratively with the PRG and were available on line through the practice website. Patients had been sent a text message with a link to the website survey and paper versions had been available in the practice. The practice manager showed us the analysis of the survey and an action plan which had been developed and discussed with the PRG. However the results and actions of the survey were not available for patients on the practice website. The results on the website related to the survey conducted in January 2012.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which had been updated in April 2014 and was available to all staff electronically.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We saw that regular appraisals took place and staff told us about the format of their appraisal. Staff told us that the practice was very supportive of training and where possible training took place at the practice.

Two of the GPs at the practice were trainers and one was a trainer convenor (a person who organises training) and GP trainer tutor. The practice had two dedicated rooms for GP trainees and also provided training opportunities for district nursing students. The practice was also a member of the Wessex GP educational trust practice accreditation programme. This was a training practice and there was an education schedule in place. This was a plan of events due to take place in the meeting/education room at the practice. It covered in house training and visits by external trainers or speakers. Practice staff and colleagues from other practices were invited to relevant training opportunities. All staff were able to contribute to the learning process and to make suggestions for future training.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines **People were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Medicines requiring refrigeration were not monitored during delivery and prescriptions were not always signed by a GP before being collected by the patient.**