Shanklin Medical 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?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 Shanklin Medical Centre on 12 March 2015. Overall the practice is rated as good.

Specifically, we found the practice to be outstanding for providing responsive services. It was good for providing a safe, effective, caring and well led service for all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example two of the practice nurses had been asked by the Island's diabetic centre to provide a presentation to all local practices about how they care for their diabetic patients as it had been identified as a model of best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- Results from the 2013 GP survey also showed 93.8% of those patients surveyed felt that their overall experience of the practice was either good or very good
- The practice had sufficient resources to meet the needs of the increased population on the Isle of Wight during the holiday season. They had been able to deal with 2000 contacts with temporary residents in the past year.
- Where patients had been affected by something that had gone wrong we saw they had been discussed with the patient and a full explanation given.

Summary of findings

- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group.
- 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.
- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

- The practice had developed a poster campaign 'Reducing accidental injury and poisoning in young children' to alert families to the risks to children that could lead to treatment in accident and emergency. This poster was distributed to all children's centres across the Isle of Wight and, at the practice's expense, published in the local newspapers.

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

Importantly the provider should:

- Have an up to date Legionella risk assessment as well as a policy for the management, testing and investigation 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?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. The practice used every opportunity to learn from internal and external incidents, to support improvement. Information about safety was highly valued and was used to promote learning and improvement. Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Significant events were all logged on a web-based patient safety software system which gave the practice an oversight risk and provided a tool for risk management. Significant events were a standing item on the weekly business planning meetings.

The practice had also linked patients to ensure that any safeguarding alert for a child was highlighted on other family members' records. Safeguarding was an agenda item on the weekly GP meetings

There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

The practice GPs conducted a number of clinical audits to assess the care and treatment of their patients. These audits had resulted in the introduction of systems designed to increase the number of patients with a learning disability attending for annual health checks.

The practice had invested in the equipment necessary to provide patients with micro suction (a way of removing ear wax which has been proved to cause less trauma to ears). They had also supported the training of a health care assistant to be able to carry out the procedure. The practice now runs a weekly clinic for patients to receive this treatment.

Summary of findings

The practice performed in house dermoscopy (a means of assessing skin lesions).This provided assurance to patients at first point of presentation that a skin lesion was not cancer. It also helped to reduce referral for benign lesions to hospital clinics leading to shorter waiting lists for patients that needed secondary care.

The practice had developed an Island wide poster campaign to alert families to the risks to children that could lead to treatment in accident and emergency.

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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group. For example by offering patients alternative means of accessing their GP or meeting their healthcare needs. The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. The practice played a significant role in instigating health initiatives and worked with the CCG and other practices to secure funding for enhanced services for patients.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The practice had responded to the needs of the practice population which was made up of a high number of patients over 75 years of age, almost 10% of their patients with over 4% of patients over 85 years of age. A number of older people lived in care homes covered by the practice. The practice had a nurse led service for patients over

Summary of findings

75 years of age. Systems had been introduced to respond the increasing needs of these patients. Audits had confirmed the continued benefit of GPs being responsible for patients in named care homes.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. Governance and performance management arrangements had been proactively reviewed and held regular governance meetings with a number of policies and procedures in place to govern activity.

High standards were promoted and owned by all practice staff and teams worked together across all roles. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. There was a high level of constructive engagement with staff and a high level of staff satisfaction. There was a large and active patient participation group which the practice chose to involve in the running of the practice.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

Staff were supported to gain further skills and qualifications to benefit patients.

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. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Each patient over 75 years of age had a named GP responsible for their care. The practice had introduced a nurse led service for these patients. The lead practice nurse made telephone calls to all patients in this age group if they had not had any contact with the practice in the preceding three months. This was to check they did not have any concerns or worries about their health or welfare. The nurse also contacted these patients by telephone on their discharge from hospital.

Patients in care homes were visited weekly by the GP allocated to the home, these visits were not part of an agreement with commissioners or the care home. This provided continuity of care for these patients and better communication with care home staff. The practice nurses and GPs had provided training for care home staff to support them in the assessment and monitoring of the people in their care.

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 medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had nurse led clinics supported by GPs to manage the health and treatment of patients with long term conditions. The nurse led diabetes team made regular visits to each of the care homes covered by the practice. This was done to support care home staff in the management of these patients. The nurses had reassessed the needs of these patients and ensured medicines were reviewed to meet the changing needs of these patients.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances. The practice had safe systems in place to highlight on the electronic clinical system those children at risk. These alerts had also been linked to other family members' records.

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 health visitors.

In response to a national audit into children's accidental injuries one of the GP partners had designed a poster campaign to highlight risks that lead to A&E attendance. This poster was then distributed to all children's centres across the island and, at the practice's expense, published in the island's newspapers.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

The practice had extended hours opening to meet the needs of those patients who needed to attend outside normal working hours. The practice was open every Monday until 8pm and every Saturday morning. The practice had introduced e mail consultations for those patients for whom it had been pre-arranged. These were mainly for follow up consultations when face to face consultations were not necessary or telephone consultations not convenient.

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 was aware of patients living in vulnerable circumstances including homeless people, and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered

Summary of findings

longer appointments for people with a learning disability. The practice had proactively worked to improve the uptake of annual health checks for patients with a learning disability. They had sent letters to those patients cared for in their own home with a personal invitation for an annual health check. This had resulted in an increase in the number of patients attending. It also gave the practice nurses and GPs opportunity to provide help and support to these patients to maintain a healthy life style.

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.

The practice provided care for a number of patients with no fixed address. They practice address was used for any referrals or prescriptions these patients needed. Staff knew these patients well and were aware of the arrangements in place for their registration with the practice.

The practice had sufficient resources to meet the needs of the increased population on the Isle of Wight during the holiday season. They had been able to deal with 2000 contacts with temporary residents in the past year.

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). 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. The practice had a GP lead for patients experiencing poor mental health.

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 where they may have been experiencing poor mental health. Staff had received training on dementia awareness as part of an island training afternoon.

Summary of findings

What people who use the service say

We spoke with 19 patients on the day of our inspection. We reviewed 17 comment cards which had been completed by patients in the two weeks leading up to our inspection.

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

All patients were complimentary about the practice staff and said were helpful, caring and professional. Patients we spoke with praised the practice for their ability to provide an appointment promptly and commented positively on the listening skills of their GPs and nurses and the way they explained their diagnosis or medicines in a way they could understand.

The results of the February 2015 NHS Friends and Family Test showed that 100% of the patients who completed the test would be extremely likely to recommend the practice to friends and family. The total for 2015 showed that 93% would be likely or extremely likely to recommend the practice. Results from the 2013 GP survey also showed 93.8% of those patients surveyed felt that their overall experience of the practice was either good or very good.

Areas for improvement

Action the service SHOULD take to improve

- Have an up to date Legionella risk assessment as well as a policy for the management, testing and investigation of Legionella.

Outstanding practice

- The practice had developed a poster campaign 'Reducing accidental injury and poisoning in young children' to alert families to the risks to children that could lead to treatment in accident and emergency. This poster was distributed to all children's centres across the Isle of Wight and, at the practice's expense, published in the local newspapers.

Shanklin Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Shanklin Medical Centre

Shanklin Medical Centre is located in Carter Road, Shanklin, Isle of Wight, PO37 7HR. The practice is close to the centre of Shanklin. Shanklin Medical Centre is part of the Isle of Wight Clinical Commissioning Group (CCG). The practice operates from purpose built premises owned by the GP partners which have been extended and updated in recent years. The practice building has 11 consulting rooms and two treatment rooms.

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 the 111 service. The Isle of Wight also has a GP led walk in service from 8am to 8pm daily. All Isle of Wight residents and visitors can access this sit and wait service.

The practice provides a range of primary medical services to approximately 11,230 patients. Patients are supported by three female and four male GP partners and one female salaried GP. This is equivalent to six full time GPs. There were two registrars at the practice at the time of our inspection. Further support is provided by a practice manager, an assistant practice manager, five practice nurses, three health care assistants and administrative and reception staff.

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

The Isle of Wight CCG covers an area where the average age is older when compared with the average for England. Shanklin Medical Centre has a significantly higher percentage of their practice population over 65 years of age compared with the average for England, with the number of patients over 85 years of age almost twice the average for England. The level of deprivation is equal to the average level of deprivation for England.

Why we carried out this inspection

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

How we carried out this inspection

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

We carried out an announced visit on 12 March 2015. During our visit we spoke with a range of staff including six GPs, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service and spoke on the telephone with two members of the virtual patient participation group. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also

Detailed findings

reviewed 17 comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed the practice website and looked at information posted on NHS Choices website.

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)

Good

Are services safe?

Our findings

Safe track record

The practice used information gathered both externally and internally to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Potential safety incidents had been acted on promptly and cascaded to practice staff with actions put in place to mitigate future risks. All the staff we spoke with demonstrated an understanding of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a safeguarding concern, medicines issues or events relating to patient treatment.

A programme of regular meetings were used to highlight and discuss any patient safety or medical alerts to ensure information was passed to GPs and nurses. There was a system in place to ensure that medicine alerts received from external bodies such as the Medicines and Healthcare Regulatory Agency (MHRA) were shared appropriately with staff and a record was kept to show that the GP or nurse had seen them and taken appropriate action. Information also included reported incidents as well as comments and complaints received from patients.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently over time and so could evidence a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were all logged on a web-based patient safety software system which gave the practice an oversight risk and provided a tool for risk management. Significant events were a standing item on the weekly business planning meetings and were also discussed at the informal, weekly, breakfast meetings. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example it had been identified that two medicines when prescribed together was contraindicated; this had resulted in GPs and nurses meeting to discuss all the checks that should take place before adding new medicines for patients including checking all electronic alerts and ensuring treatment plans were reviewed.

We saw the system used to manage and monitor incidents. Records were completed in a comprehensive and timely manner. Where patients had been affected by something that had gone wrong we saw they had been discussed with the patient and a full explanation given, they were informed of the actions taken.

Reliable safety systems and processes including safeguarding

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children and they had the necessary training to level three in children's safeguarding as well as updates about vulnerable adults, to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. Staff were aware of the importance of protecting vulnerable adults and children from abuse and knew how to recognise the various signs and symptoms and how to contact the relevant agencies. Information relating to safeguarding was prominently displayed throughout the practice and gave staff contact details for reporting any concerns they may have. There was also clear guidance for all staff about their responsibilities in relation to safeguarding. Training records showed that staff had received on line training in safeguarding children and adults in the last 12 months. Child and adult safeguarding had also been the subject of training at practice closure afternoons within the last two years. (Practice closure afternoons occur three times a year. GPs and staff meet with other practices from the Island for a themed programme of training). The lead GP provided safeguarding training for all new staff and had developed a presentation which had been written in collaboration with two hospital consultants.

GPs used the required codes on their electronic case management system to ensure risks to children were clearly flagged and reviewed. The practice had also linked patients to ensure that any safeguarding alert for a child was highlighted on other family members' records. Safeguarding was an agenda item on the weekly GP meetings, we saw minutes of meetings where safeguarding issues had been shared and discussed.

Good

Are services safe?

A chaperone policy was in place and posters advertising this were seen in the patient waiting room, consulting rooms and treatment rooms (a chaperone is a person who acts as a safeguard and witness for a patient and healthcare professional during a medical examination or procedure). Practice nursing staff and health care assistants acted as chaperones.

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 treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice nurses monitored the medicines cold chain (a cold chain is the system for storing vaccines and medicines within the safe temperature range of between two and eight degrees Celsius). We saw records which confirmed checks on temperatures of the fridges were made and recorded electronically. Nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance.

Expired and unwanted medicines were disposed of in line with waste regulations.

Patients were able to request repeat prescriptions at the practice, by post or online, patients told us they did not have any concerns about the process. The practice was able to issue repeat prescriptions the same day if a request was made before 12.30pm. The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medicines to ensure the medicine was still safe and necessary. There were systems in place to ensure patients attended their annual medicines review and that repeat prescribing did not continue without the review. Staff explained how the repeat prescribing system was operated.

GPs were responsible for deciding the contents, checking and managing the medicines they carried in their own bags. Individual GPs ensured the medicines were in date and ready to use if necessary.

The practice did not hold any controlled drugs on the premises (these are medicines that require extra checks and special storage arrangements because of their potential for misuse).

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. The practice was cleaned by an external company whose staff had been subject to Disclosure and Barring Service (DBS) checks and had signed the practice's confidentiality agreement. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We saw there were cleaning schedules in place and cleaning records were kept. We saw copies of these for the past three years. The practice manager met regularly with the company to discuss progress and other issues to ensure standards of cleanliness were maintained. We saw a record of the meeting schedule and signed agreements which included a cleaning monitoring sheet in each room. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

One of the practice nurses was the lead in infection control; they were supported by the senior GP partner and the practice manager to complete the 'Infection Control Team'. The lead nurse had undertaken further training to enable them to provide advice on the practice's infection control procedures with refresher training within the last 12 months. We saw from training records that nurses and administration staff had taken part in online infection control training within the last 12 months. There were no records of the training completed by GPs in this subject.

We saw that the lead had carried out regular audits the last one took place in November 2014. We saw that all actions from the preceding audit in 2013 had been completed, For example, upholstered chairs had been replaced throughout the practice by wipe able ones and instructions for hand washing had been displayed above every sink.

An infection control policy and supporting procedures and protocols were available for staff to refer to, which enabled them to carry out effective infection prevention and

control. For example, a hand hygiene policy and audit, clinical waste protocol and needlestick injuries policy. Personal protective equipment including disposable gloves, aprons and coverings were available for staff. The policies and procedures had been reviewed and updated annually.

The practice manager told us the practice had carried out a risk assessment in relation to Legionella a number of years before. (Legionella is a bacterium found in the environment which can contaminate water systems in buildings). The risk assessment was not available for us to see or a record of the level of risk that had been identified. The practice did not have a written scheme for the management, testing and investigation of Legionella. However there was a system in place for the daily flushing of little used water outlets.

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 was calibrated annually, with the last test carried out in October 2014. (Calibration is a means of testing that measuring equipment is accurate). Patients had been encouraged to bring in the blood pressure machines they used at home to be tested. We saw that a total of 47 pieces of equipment had been calibrated. Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, 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 staff to the practice to ensure the person was of good character and had the required qualifications or skills.

We saw minutes of GP meetings where staffing levels had been discussed. This had been in relation to staff numbers and mix of staff and skills 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, administrative staff and GPs to cover each other's annual leave or sickness. The practice had a made a decision not to use locum GPs so GPs discussed and organised well in advance proposed absences.

The practice had audited the demand for GP consultations and the increasing demand for consultations by the ageing patient population and was aware of the number of consultations they would need to provide to meet that need. They told us there were 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 was able to show us the minutes of meetings where discussions had taken place and actions agreed. These included the development of the nurse role and the possible employment of a pharmacist to meet patients' needs and expectations.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment and emergency alarms. A fire risk assessment had been carried out after refurbishment to the building and this had been reviewed annually. Fire alarms were tested weekly and a fire drill performed annually. Staff training records showed staff had received training in fire safety, COSHH awareness (control of substances hazardous to health), health and safety, trips, slips and falls and display screen equipment. These were all part of the annual training the practice had identified as mandatory.

The practice ensured that appropriate risk assessments were carried out in relation to both patients and staff. For example a risk assessment had been carried out to assess the risks to a member of staff during their pregnancy and also following the purchase of a wheelchair the risk had been assessed for the patients and staff who may use it.

There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record. Alerts were also attached to the records of vulnerable families and children at risk. These were also highlighted on the records of close family members.

Good

Are services safe?

We saw staff were able to identify and respond to changing risks to patients such as deteriorating health and well-being. The practice held quarterly palliative care meetings, weekly partners' meetings and breakfast meetings each day 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 using an automatic external defibrillator (AED) (a machine which is used in the emergency treatment of a patient suffering a cardiac arrest) and adult basic life support. GPs and nurses had also taken part in annual anaphylaxis and paediatric resuscitation training. (Anaphylaxis is a sudden allergic reaction that can result in rapid collapse and death if not treated). Emergency medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location. These medicines were found to be available and within their use by dates. These were checked monthly with the checks recorded electronically.

All staff when asked knew the location of the AED, oxygen, and emergency medicines. 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 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. This plan had been reviewed annually to ensure it reflected current arrangements. The practice had made arrangements with the local church hall to use their premises, should the practice building become unusable, to minimise the risk of a disruption to the service for patients. There was a system in place to back up patient records to ensure they are not lost through an adverse incident or IT failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

The practice ran nurse led clinics in specialist areas such as diabetes, heart disease and asthma with dedicated GP support; this allowed the practice to focus on specific conditions. GPs and nurses we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us they supported all staff to continually review and discuss new best practice guidelines for the management of long term conditions.

We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example the practice nurses responsible for the management of diabetes had visited patients in care homes where they had supported staff with patients' diets but also reassessed the changing medication needs of the frail elderly.

We looked at the data available from the local Clinical Commissioning Group of the practice's performance for a number of outcomes; all were comparable to or above similar practices. For example the number of patients with diagnosed dementia who had been reviewed face to face within the last 12 months and the measurement of cholesterol and blood pressure for patients with diabetes in the last 12 months.

One of the GP partners had completed an audit to assess the benefit of in house dermoscopy which had been introduced into the practice in 2013. This means of assessing skin lesions was used as a method of excluding benign skin disease. This provided assurance to patients at first point of presentation that a skin lesion was not cancer. It also helped to reduce referral for benign lesions to hospital clinics leading to shorter waiting lists for patients that need secondary care.

The practice used computerised tools to identify patients with complex needs to ensure they were invited to the practice at appropriate intervals for an assessment of their needs. Patients who relied on long term medication were also regularly assessed and their medication needs reviewed.

The practice had a process in place for the GPs and nurses to contact and review patients recently discharged from hospital.

There was a system in place to ensure that each GP had an allocated colleague who viewed all their correspondence including test results on days they were not in the practice. 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 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 specialist training in diabetic care. There was a recall register for patients with diabetes which ensured they had a formal yearly review. The practice nurse was in contact with many patients by telephone to provide help and advice. There was evidence of frequent contact with patients especially those newly diagnosed with a long term condition. The frequency of these contacts was dictated by the needs of individual patients. There was open access for these patients to discuss their condition with the specialist practice nurses. Patients newly diagnosed with long term conditions were identified by the practice to ensure they received related health checks, which were carried out by the practice nurse with support from the GPs. The practice had established links with the diabetes centre who they met with annually for support and advice. The centre was also available to support staff and offer advice about individual patient needs.

Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. The practice undertook regular clinical audits and the Quality and Outcomes Framework (QOF) was used to assess the practice's

Good

Are services effective?

(for example, treatment is effective)

performance (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries). One of the GP partners provided the lead for QOF to ensure the practice regularly reviewed their achievements against the QOF.

The practice manager was a regular attender at practice manager meetings where representatives from neighbouring practices met to discuss ways of improving outcomes for their patients. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients with diabetes who last had a blood pressure reading below 140/80 in the year to March 2014 was higher than the national average figure for England. QOF was used to monitor the quality of services provided. The QOF report from 2013-2014 showed the practice was supporting patients well with long term health conditions such as, asthma and diabetes. They were also ensuring childhood immunisations were being taken up by parents. The practice achieved 100% in the 2013-2014 QOF.

The practice demonstrated exceptional standards of care for diabetic patients and had a GP with a special interest in diabetes. The practice demonstrated best practice in keeping with NICE guidelines and aimed for better levels of 3 month blood sugar control than would normally be achieved in a community diabetic setting. The practice met with hospital consultant colleagues to get advice regarding the care of diabetic patients and therefore maximise the blood sugar control of these patients. This has provided health benefits for patients in terms of reducing their risk of diabetic complications such as eye problems, kidney problems and cardiovascular disease

The practice was aware of latest medical research which suggested that elderly patients admitted to hospital with an episode of hypoglycaemia (low blood sugar readings) have an increased risk of mortality in the year following their hospital admission. The practice demonstrated how they proactively managed these patients, by identifying and treating them during the 12 month period following their admission. This protocol reduced adverse health outcomes for patients.

The practice has a system in place for completing clinical audit cycles. We saw evidence of complete clinical audit cycles, one of which showed the practice had audited patients who lived in care homes and the model of allocating a GP to each care home. The completed audit cycle had shown that the outcomes for patients had been improved. The audit had identified that the number of visits had not decreased but GPs felt patients were very much better when they saw them and agreed that a more supportive relationship had built up with care home staff and patients.

The practice had carried out other audits to improve patient care for example an audit on the uptake of annual health checks for patients with a learning disability. The completed cycle followed the introduction of personal invitations to patients, who were cared for at home rather than in a social care setting, and saw an increase in the number of patients who received an annual health check.

Effective staffing

All the staff we spoke with, nurses and those in administrative roles told us they were well supported by the GP partners and the practice manager. There was an induction programme for newly recruited staff. All staff as part of their induction followed a programme to ensure they were aware of their roles and responsibilities and practice procedures.

The practice supported the staff and nurses to complete training and to gain further qualifications. Staff were supported with paid time to complete the training and the practice bore the costs of training courses. We saw evidence of the costs incurred for the practice manager and health care assistant to complete courses to benefit the practice. Staff were allowed day release and paid exam leave as part of that support.

Staff had been developed in their roles for the benefit of patients. For example a healthcare assistant had been trained by a hospital consultant to carry out micro suction (a way of removing ear wax which is less traumatic to the ear than syringing.) They were then able to provide a weekly clinic which we saw was well booked for patients to have this procedure.

There was an annual appraisal system in place for staff. Staff we spoke with confirmed 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. The practice had a system of on-line training which they required staff to complete each year; some GPs also completed the online training tracker

Good

Are services effective?

(for example, treatment is effective)

for their own personal development. The practice supported staff by providing protected time to complete these training modules which included child and adult safeguarding and the Mental Capacity Act 2005. Training records confirmed that all staff were up to date in these mandatory subjects. All administrative staff, GPs and nurses had received face to face training in basic life support, with further training in paediatric life support and anaphylaxis for nurses and GPs. All practice staff took part in training three times a year organised for the whole of the Isle of Wight. This training was tailored to the needs of the staff groups.

Nursing staff had taken part in a range of training courses to improve patient care such as diabetes, cervical cytology, immunisations and spirometry training. GPs took part in a peer review appraisal; these appraisals formed part of their revalidation with the General Medical Council (GMC).

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, the out-of-hours and walk in centre both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked with others to improve the service and care of their patients. The nurses with patients' permission referred them to the community health trainer and other national organisations. There were arrangements in place for other health professionals to use the practice premises to provide services to patients, such as the podiatrist who carried out foot health checks for patients with diabetes.

Antenatal and postnatal care was provided by midwives and health visitors, based at a nearby children's centre. The practice had regular communication with the health visiting team, especially in relation to any safeguarding issues. Health visitors were regularly invited to the practice's weekly meeting, we saw minutes of these meetings where specific cases had been discussed and relevant information shared.

The practice held quarterly palliative care meetings to which other health care professionals were invited to attend when appropriate. These meetings were attended by district nurses, Macmillan nurses and all the GPs. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information and ensuring best treatment outcomes for patients.

One of the GP partners had worked with the local hospital A and E department consultant to instigate training for staff there in dementia care. This was in response to the problems encountered by patients with dementia needing urgent hospital care.

Two of the practice nurses had been asked by the Island's diabetic centre to provide a presentation to all local practices about how they care for their diabetic patients as it had been identified as a model of best practice.

The practice was working with neighbouring practices within the Isle of Wight CCG. The practice manager was leading the newly formed GP federation. This had been set up to allow the group to bid for services, increase buying power for the practices and to work collaboratively, for example the sharing of staff using funds from the transformation fund to create locality hubs. The practices were working together to commission new services for their patients.

Information sharing

The practice used several methods communicate with other providers. For example, there was a shared system with the local out of hours provider, the Island's walk in centre and the Island's hospital, to enable patient data to be shared in a secure and timely manner. Although we saw that patients were given the choice to opt out of this system of sharing information should they wish to. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system if required. (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).

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. All staff were fully trained on the system, and commented positively about the system's safety and ease

Good

Are services effective?

(for example, treatment is effective)

of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice had historic paper patient records which were used if necessary to review medical histories. The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they implemented it in their practice. Training records showed that all practice staff had received training in the principles of MCA. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes. GPs gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. For example how, after family discussions with the GP, a best interest decision had been made for the treatment of a patient with a severe learning disability.

There was a practice policy for documenting consent for specific interventions. For example, for some family planning procedures and for minor surgery. Verbal consent was documented in the electronic patient notes with a record of relevant discussions. An introduction to consent was a subject which all staff covered annually as part of the practices' on line training programme.

Patients said that they felt involved in decisions about their care and treatment. They said they were given time to consider options available and were never rushed. They felt they had enough information to make informed decisions about their care.

Health promotion and prevention

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

In response to a national audit into children's accidental injuries one of the GP partners had designed a poster campaign to highlight risks that lead to A&E attendance. The poster aimed at alerting people to the risks and what action should be taken was produced by the practice. This poster was then distributed to all children's centres across the island and, at the practices expense, published in the Island's newspapers. This campaign had been recognised by Health Education Wessex and a certificate of congratulations awarded for the nomination of High Performing Education and Training Team of the Year in 2014.

The practice offered NHS Health Checks to patients in specific age groups and to all new patients. These were carried out by the practice nurses who would discuss the findings with patients and refer to a GP if a medical opinion or diagnosis was required.

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. The practice offered home visits to give flu vaccinations or carry out health checks for eligible patients who were housebound.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with 19 patients and reviewed 17 comment cards. All patients were complementary about the care that they 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, the virtual Patient Reference Group report 2014 and the practice's results of the Friends and Families test. The evidence from all these sources showed patients were very satisfied with how they were treated and described the staff as friendly, respectful, polite and helpful. The NHS England GP survey showed that 93.8% of those who responded rated their overall experience of the practice as either good or excellent. The majority of patients told us that the GP or nurse they saw listened to them and gave them enough time during their consultation, they did not feel rushed.

Staff told us how they respected patients' confidentiality and privacy. Some telephone calls were made and answered by staff who were not sitting at the reception desk this helped keep patient information private and ensured that confidential information could not be overheard. During our observations in the waiting room we did not overhear any personal information. A sign requested that patients stood back from the reception desk until called forward this helped to protect the privacy of the patient in conversation with the receptionist. All reception and administration staff had completed information governance training in the past 12 months and this was subject to annual refresher training. Those we asked were able to demonstrate how they ensured patients' privacy and confidentiality was maintained.

Consulting rooms had been designed with privacy walls to separate the examination area from the rest of the room 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

Patients 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 listening skills of all the staff.

Data from the national patient survey showed 87% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results.

Staff told explained that translation services were available for patients who did not have English as a first language. They described how this service had been used recently and how the GP consultation had been extended to ensure there was sufficient time to confirm the patient understood their treatment.

Patient/carer support to cope emotionally with care and treatment

The practice was able with a patient's consent refer them to the community health trainer who made contact and supported the patient to access the help they needed. This could include advice on healthy lifestyle issues or preventing social isolation for example accessing transport or community groups.

The practice also referred patients to Isle Help, where support for long term conditions could be accessed.

Notices in the patient waiting room told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer.

The practice met regularly with the community care team and the palliative care team to ensure all professionals are aware of end of life wishes. GPs told us that they involved families and carers in end of life care and worked to provide help and support for those patients.

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

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

New patients were allocated to a GP on patient list size; if patients had a preference for a male or female GP this was accommodated. Patients could also request a specific GP for their appointment other than the GP they were registered with. All patients over 75 had a named GP in line with current recommendations.

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. The practice had responded to the needs of the practice population. For example the high number of patients over 75 years of age, this was almost 10% of their patients with over 4% of the practice population was over 85 years of age. A number of older people lived in care homes and were patients of the practice.

The practice had a nurse led service for patients over 75 years of age. The nurse telephoned all patients in this age group on discharge from hospital and also if there had been no contact with the practice in the previous three months. This helped the practice with the early identification of healthcare needs. Each care home within the practice area was allocated a GP. GPs visited the care homes each week, as well as responding to urgent requests for home visits. The allocation of GPs to care homes was initiated after an audit of GP visits. The aim was to maximise GP time, this had also resulted in consistency for patients and care home staff. Communication and support for care homes had improved. GPs and practice nurses provided care home staff with education and training to improve outcomes for patients. For example, offering diet advice and training care home staff to monitor diabetic patients and to administer insulin.

The practice was able to issue repeat prescriptions for patients the same day if a request was made before 12.30pm. Any prescription request made after 12.30 pm was ready the following afternoon.

Extended hours opening until 8 pm was available every Monday and the practice was open every Saturday morning between 8 am and 11 am for patients who could not attend during working hours due to other commitments. Nurse appointments were available each day until 6.30pm. Lunchtime appointments were also offered if patients needed to be seen by a GP the same day. During our inspection we spoke with 19 patients and reviewed 17 comment cards, all commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the practice.

The practice worked collaboratively with the Isle of Wight Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. The practice manager lead the local GP federation were GP practices worked together to provide new services their patients. Negotiations with medical defence organisations had enabled a system to be set up whereby local practices could share staff if necessary.

The practice had a virtual patient participation group (vPPG) of approximately 370 patients. The vPPG reflected the patient population in respect of age. The last practice patient feedback survey in 2014 had been designed based on the priorities identified and agreed by the practice and the vPPG. Following the survey the practice had produced an action plan. Such as offering patients alternative means of accessing their GP and to review the viability of enhanced Nurse roles to increase access to healthcare by patients. We saw that there were a variety of options now in place for patients to access their GP such as telephone and email consultations. Minutes of GP partners meetings showed that the training and support of practice nurses to provide enhanced nurse roles had been discussed and considered.

A member of the PPG made themselves available to the inspection team and was keen to promote and compliment the responsiveness of the practice. They explained how they worked with the practice for the benefit of patients. The PPG member had formed part of the interview panel during the recruitment process for the last GP.

The NHS England Area Team and CCG told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example patients who had work commitments, those with long term conditions and the elderly including those living in care homes.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had provided dignity at work and equality and diversity training for staff which the practice training record confirmed had been completed in the last 12 months. This was a subject considered by the practice to be mandatory for all staff.

The premises were purpose built; we saw that the waiting areas was large enough to accommodate patients with wheelchairs and prams, recent improvements to the building included a platform lift to allow independent access for patients to the first floor consulting rooms. There was a section of the reception desk at a lower height to provide access for patients unable to use the higher main counters. There were disabled toilet facilities available.

The practice had a population of mainly English speaking patients however the practice was able to organise telephone interpretation services for patients whose first language was not English.

Access to the service

The practice was open from 8.15am to 6.30pm Monday to Friday with appointments until 8pm each Monday. The practice opened every Saturday between 8am and 11am. Patients were able to access same day appointments if medically necessary and those we told us that it was usually easy to get an appointment at a time which suited them. Practice nurses were available to see patients each day between 9am and 5.30pm and on Mondays between 6.30pm and 8pm.

Each day the practice had a duty doctor available during morning surgery and between 3pm and 6.30pm; this role was rotated by the GPs. Any patient who needed to be seen urgently was able to see the duty doctor if their GP was not available or fully booked. The practice also provided email consultations for patients. These were used by some of the GPs to provide advice and support to patients who did not need a face to face consultation. The GP was able to copy the email consultation directly into the patients' electronic record. There were systems in place to ensure patients' emails were opened and responded to. Each GP had time allocated each day to carry out telephone consultations.

Comprehensive information was available to patients about appointments on the practice website and the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments, by telephone, in person and through their online system. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients and also details of the Island's walk in service.

Longer appointments were available for people who needed them and those with long-term conditions. Staff explained how these appointments were arranged for example to give added time to a patient who used a translation service. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed them.

Patients told us they were satisfied with the appointments system. Comments received from patients showed that patients in urgent need of treatment had been able to make appointments on the same day.

Listening and learning from concerns and complaints

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

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

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed that the practice responded quickly to issues raised. We looked at the record of complaints for the last 12 months. There had been a total of eight. Records showed that all complaints had been responded to in a courteous manner by the practice manager. Any learning from each complaint had been recorded.

The practice regularly analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

There was evidence of shared learning from complaints with staff. We noted from minutes of meetings and by talking with staff that complaints were discussed to ensure all staff were able to learn and contribute to improvements at the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to provide the best possible clinical, patient, partner and staff experience within available resources. The vision was underpinned by identified and recorded values and objectives. These were published as part of the practice's patient survey report, available on the practice website and available as a leaflet at the practice. GPs and staff told us there was an open culture and they all worked as a team. Each person we asked felt valued as part of their team and the wider practice team. Decisions were made democratically and patient care was delivered consistently by GPs or shared if this benefitted patients.

We spoke with six GPs, two practice nurses, the practice manager and their deputy and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these.

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

The practice worked with other practices towards providing improved services for their patients. For example there had been a successful bid for the practice to share a substantial amount of money to set up locality based services for patients representatives from the practice were members of the steering group.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at a number of these policies and procedures, all the policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. Each GP partner had a lead role for each area of clinical practice such as prescribing, palliative care, learning disability and diabetes. Each GP partner also had responsibility for a specific subject in relation to the running of the practice such as finance and Health and Safety. Staff were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF was a standing agenda item at each practice meeting. Data was discussed and action plans produced to maintain or improve outcomes for patients.

The practice manager told us that they met regularly with other practice managers from the Isle of Wight Clinical Commissioning Group. This gave the practice the opportunity to measure their service against others and work collaboratively to identify areas for improvement and to identify best practice.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

The practice had robust arrangements for identifying, recording and managing risks. For example we saw staff meeting minutes which recorded the discussions around staffing levels and improving the service for patients. We saw minutes of a meeting that had been held where each GP had identified their top three priorities for the practice. These priorities, such as GP recruitment and staffing had been discussed and actions agreed. For example the GPs had discussed ways of improving the service to patients which included the skill mix and development of existing staff and the use of other healthcare professionals in the future.

The practice had a business continuity plan which had been regularly updated to ensure it identified any possible risks to service disruption. One of the GP partners and the practice manager kept copies of these documents away from the practice. There was a lead for Health and Safety, whilst individual departments were responsible for their own environment the Health and Safety lead was able to assess the overall risks.

Leadership, openness and transparency

There was a plan of regular team meetings which took place at the practice. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

Are services well-led?

Good

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

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

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example equality and diversity, age discrimination, human rights and the induction programme, which were in place to support staff. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing staff whose roles were in reception or administration.

A representative from the virtual patient participation group (vPPG) told us that they were able to communicate easily with the practice and felt the practice manager and GPs were responsive to their suggestions and the feedback from patients. They had been part of the latest recruitment of a GP and represented the vPPG on the interview panel.

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

The practice had gathered feedback from patients through their annual satisfaction survey published in March 2014, feedback from their active vPPG the Friends and Family Test (FFT) and from compliments and complaints. They had reviewed this feedback with the vPPG five times between March 2014 and March 2015. We were told by representatives of the vPPG that the practice was very responsive to their suggestions and changes had been made to the practice as a result of their feedback. For example the practice had improved the choices for patients with regard to alternative access to their GP with the introduction of email follow ups and an increased number of telephone consultations.

There had been 221 responses to the patient survey which was conducted in March 2014. The survey questions had been developed collaboratively with the vPPG and patients were offered a number of ways of completing the survey. Questions were focused on access to GPs and nurses and to gauge patients' opinions on how and by whom their medical condition should be managed. The practice manager showed us the analysis of the survey and the subsequent action plan which had been developed.

In March 2015 the practice had produced an annual report on the actions they would be taking in the coming year as a result of the various feedback they had received. This included considering a move to prescribing repeat medication on a 3 month basis for patients who were on long term stable medications and the introduction of hand sanitisers as a result of a comment received from the FFT. A copy of these planned actions was available for patients on the practice website.

The practice involved staff in decisions about the practice. Reception and administration staff told us how they had been involved in the design of the reception area when the practice had been refurbished. The GPs had encouraged those staff who worked in the reception area to liaise with the architect to design the area to meet their needs for an efficient working environment and the needs of the patients.

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 all staff we spoke with confirmed they had taken part in the appraisal process. Staff told us that the practice was very supportive of training and provided regular training or supported them to attend training elsewhere.

Staff used protected time during their working day to complete on line training. We saw evidence that the practice had supported staff financially and through day release to develop their role which had improved outcomes for patients and the practice. For example the practice had arranged for the training of one of the healthcare assistants (HCA) to receive training in micro suction. This procedure required the use of specialist equipment that had been purchased by the practice. This is a method of removing ear wax for patients. There is evidence that this procedure is less traumatic to the patient's ear and providing the service at the practice it has improved access for patients. The HCA provided weekly clinics for micro suction which were invariably fully booked.

Are services well-led?

Good

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

All staff were able to contribute to staff meetings and to make suggestions for future training. We also saw in meeting minutes that there was

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally as appropriate to ensure the practice improved outcomes for patients.