Clift Surgery Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Clift Surgery on 18 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services to older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

• Risks to patients were assessed and well managed.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

• The practice had good facilities and was well equipped to treat patients and meet their needs.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

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

Action the provider MUST take to improve:

- Ensure all prescriptions were reviewed and signed by a GP before they were given to the patient.
- Ensure that fridge temperatures were recorded and that historical records were maintained.
- Implement better key security for controlled drugs and prescription forms – at the time of our inspection these were accessible by all staff entering the dispensary.
- Implement prescription security – serial numbers were not recorded.
- Ensure that standard operating procedures (SOP) for dealing with medicines were in place. Some of the SOPs, especially for controlled drugs were not complete as they needed to reflect the procedures at the practice.

Action the provider SHOULD take to improve:

- Learning from errors – we could not see consistent evidence of learning from errors, trend analysis etc. Some errors had repeated despite a significant event.
- Medicines Alerts – received by administration staff, but dispensary should have ownership of the process.
- Emergency medicines and "Doctors' Bags": There should be a rationale for selecting drugs, this was not clear, for example; no drugs were carried for cardiac emergencies.

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 providing safe services as there are areas where improvements must be made.

Systems were in place for reporting, recording and monitoring significant events. Infection prevention and control systems were in place and regular audits were carried out to ensure that all areas were clean and hygienic. Appropriate checks were made on all staff before they started to work. Staff files were comprehensive and complete. Arrangements relating to the availability of safe and secure storage of medicines and vaccinations were not effective.

We found that not all prescriptions were reviewed and signed by a GP before they were given to the patient. Fridge temperatures were recorded but historical records not kept. The key for access to controlled drugs and prescription forms was currently accessible by all staff entering the dispensary. In relation to prescription security, currently serial numbers are not recorded. Standard operating procedures (SOP) for dealing with medicines were in place but some of the SOPs, especially for controlled drugs were not complete as they needed to reflect the procedures at the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams to provide effective care.

Are services caring?

Good

The practice is rated as good for caring.

Patients said that they were well informed about their care and treatment. We observed people being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient privacy, dignity and confidentiality when registering or booking in patients.

The patients we spoke with, and the comments we received were complimentary of the care and service that staff provided.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice obtained and acted on patients' feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care.

The practice understood the needs of their patient population and this was reflected in the setup of the practice environment and systems used to meet the needs of their patients.

Patients told us they could always get an emergency appointment and waiting time for routine appointments was satisfactory.

Are services well-led?

Good

The practice is rated as good for well-led.

There was a clear leadership structure and staff felt supported by management and a culture of openness and honesty was encouraged.

The staff worked as a team and ensured that patients received a high standard of care. Staff had received inductions, regular performance reviews and attended staff meetings.

Risks to the safe and effective delivery of services were assessed and addressed in a timely manner. A suitable business continuity plan was in place. The practice had a number of policies and procedures to govern activity and regular governance meetings had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

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 the needs of the older people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Patients in this population group received safe, effective care which was based on national guidance. Care was tailored to patient needs, there was a multi-disciplinary input and was reviewed regularly.

The practice provided regular clinics for patients with diabetes, respiratory and cardiac conditions. The practice had two nurses who had received training and provided diabetic care and chronic obstructive pulmonary disease care in their own clinics.

Families, children and young people

Good

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

The practice followed national protocols and staff were aware of their responsibilities and the various legal requirements in the delivery of care to people in this population group. They worked with other health and social care providers to provide safe care.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. The practiced was working with midwives and health visitors to provide shared continuity of care and communication. The practice endeavoured to register family groups with the same named GP.

The practice had specific protected appointments for children after school.

Summary of findings

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).

There was an appropriate system of receiving and responding to concerns and feedback from patients in this group who had found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group whose circumstances may make them vulnerable.

There was evidence of good multidisciplinary working with involvement of other health and social care workers. Staff were trained on safeguarding vulnerable adults and child protection.

The practice had regular meetings with the Integrated Care team involving the community matron (who had a virtual ward list of patients vulnerable to admission), district nurses, social worker and a Community Psychiatric nurse. The aim was to discuss vulnerable patients in the community either through health, social or psychiatric issues, and try to formulate a combined plan of action.

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 patients with dementia).

The practice had a shared care approach to dementia in the nursing homes and community and actively identified patients with possible dementia and referred through the dementia pathway.

The practice ensured that good quality care was provided for patients experiencing poor mental health. The practice offered proactive, personalised care that met the needs of the older people in its population and had a range of enhanced services, for example in dementia.

Summary of findings

What people who use the service say

During our visit we spoke with six patients, including two members of the patient participation group and reviewed 21 comments cards from patients who had visited the practice in the previous two weeks. All the feedback we received was positive. Patients were complimentary about the practice staff and the care and treatment they received. Patients told us that they were not rushed, that the appointments system was effective and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Areas for improvement

Action the service MUST take to improve

• Ensure all prescriptions were reviewed and signed by a GP before they were given to the patient.

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• Implement better key security for controlled drugs and prescription forms – at the time of our inspection these were accessible by all staff entering the dispensary.

• Implement prescription security – serial numbers were not recorded.

• Ensure that standard operating procedures (SOP) for dealing with medicines were in place. Some of the SOPs, especially for controlled drugs were not complete as they needed to reflect the procedures at the practice.

Action the service SHOULD take to improve

• Learning from errors – we could not see consistent evidence of learning from errors, trend analysis etc. Some errors had repeated despite a significant event.

• Medicines Alerts – received by administration staff, but dispensary should have ownership of the process.

• Emergency medicines and “Doctors’ Bags”: There should be a rationale for selecting drugs, this was not clear, for example; no drugs were carried for cardiac emergencies.

Clift Surgery Partners

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 practice manager. This practice was a dispensing practice and also in the inspection team was a pharmacy specialist advisor.

Background to Clift Surgery Partners

The Clift Surgery, Minchens Lane, Bramley, Basingstoke RG26 5BH is located in a rural area. The practice covers three moderate sized villages having both a rural and commuter population.

The practice is responsible for providing primary care services to approximately 6,500 patients. The Clift Surgery has a general medical services (GMS) contract to provide services to patients living in the surrounding area. The practice provides an in house dispensary serving 90% of registered patients and can provide acute and repeat prescriptions.

The practice has an active learning and training environment. One of the partners attained training status for the practice in 2006 and the practice is now an established training practice being reaccredited in 2012.

The practice reception is open Monday to Friday 8.30am to 6.00pm although telephone calls are taken until 6.30pm. The dispensary is open Monday to Friday 8.30am to 1.00pm and 2.00pm to 6.00pm. Routine surgeries are held Monday to Friday from 9.00am to 12 noon, 2.00 to 4.00pm and 3.30 to 5.30pm. The practice also offer extended hours, for pre-booked appointments only, as follows: On the first Saturday of the month 9.00am to 12 noon Tuesday 7.00 to 8.00am. Alternate Wednesdays 7.00 to 8.00am alternate Thursdays 6.30 to 8.00pm.

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

The practice has three GP partners and a salaried GP who together provide an equivalent of three and a half full time staff. In total there are one male and two female partner GPs. The practice employs one salaried female GP. The GPs are supported by two nursing staff and two health care assistants. The practice also has an administration team which consists of receptionists, administrators, secretary, reception manager, IT manager and the practice manager.

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 held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

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

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

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

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. This included reported incidents and national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We saw a number of examples where this information was appropriately managed and action was taken when necessary. An example seen was when receptionists were taking appointments there had been a concern that patients with similar names might be mixed up. This was discussed and receptionists confirmed patient identification when booking appointments.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. We saw an example where systems within the practice had been changed to minimise further risks. The example we reviewed identified an event where errors were found in the checking of medications dispensed. This highlighted the need for GPs to take responsibility for checking the medications and was discussed at a dispensary meeting. As a result extra staff were employed at dedicated times for doctors to check medications.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in specific level three training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Examples were given by staff of safeguarding concerns they had raised. Any case of concern was discussed during the weekly clinical meetings.

Staff told us that they understood what "whistleblowing" was. They were able to explain the actions they would take if they needed to use this process and felt that if required they would have confidence to start the process.

The practice offered patients the services of a chaperone during examinations if required. (A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure.) We saw that details of this service were displayed around the practice building for patients to read and staff told us that this service was offered to patients.

Medicines management

We checked medicines stored in the dispensary and medicine fridges and found they were stored securely and were accessible to all staff. Practice staff monitored the refrigerator storage temperatures and appropriate actions were taken when the temperatures were outside the recommended ranges.

The practice maintained a log of fridge temperature checks, daily during practice opening hours. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably. Although we were unable to review historical temperature records as they were stored on a computer and the nurse was unable to access them on the day of the inspection.

Processes were in place to check medicines were within their expiry date and suitable for use.

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. This was done to reassure the practice that patients' repeat prescriptions were still appropriate and necessary.

There was a system in place for the management of high risk medicines which included regular monitoring in line with national guidance. The practice held stocks of controlled drugs (CDs) (medicines that require extra checks and special storage arrangements because of their potential for misuse). For example, controlled drugs were stored in controlled drugs safes but the keys for CDs and prescription forms were accessible by all staff entering the

dispensary. Records were kept of who had collected the controlled drugs and the correct processes were followed. There were arrangements in place for the destruction of controlled drugs which followed the prescribed guidelines.

Appropriate action was taken based on the results. Standard operating procedures (SOP) for dealing with medicines were in place but some of the SOPs, especially for controlled drugs (CDs) were not complete as they needed to reflect the procedures at the practice. These needed to be updated, especially around expired CDs and disposal of unwanted medicines. Some SOPs referred to handling and disposal of cytotoxics but dispensary staff did not know how to identify them.

Not all prescriptions were reviewed and signed by a GP before they were given to the patient. On the day of inspection the practice had brought in procedures for handling blank hand written prescription forms in accordance with national guidance and these were now tracked through the practice and kept securely at all times. Prescription pads were securely kept in a locked cupboard within a designated area of the practice.

A significant event had been logged where a patient was dispensed the wrong medication. This was a dispensing error, second and third checks missed the error. This incident had highlighted the need for the GP to take responsibility in checking medication and was discussed at dispensary meeting. Extra staff have been employed and dedicated time allowed for doctors to check medications.

We checked the emergency drug kit and found that all the medicines were in date. There was a log maintained with the expiry dates of all the medicines available in the kit, this was scheduled for weekly checking but records showed that this was only done once a month and there had been no checks completed for end January 2015.

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

Cleanliness and infection control

All areas of the practice appeared to be well maintained, clean and fit for purpose. An infection control policy and supporting procedures was available for staff to refer to, which enabled them to plan and implement infection control measures. For example, personal protective equipment which included disposable gloves and aprons was available for staff to use and staff were able to describe how they would use these in order to comply with the policy. There was a nominated infection control lead who had attended suitable training and had then cascaded training to the practice staff. An infection control audit had taken place in December 2014 and an action from this audit ensured that staff had access to a current policy document.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms.

Sharps boxes were provided and were positioned out of the reach of small children.

Clinical waste was stored safely and securely before being removed by a registered company for safe disposal. We examined records that detailed when such waste had been removed.

We saw that a risk assessment had been conducted in relation to legionella testing and we were told that the practice manager was in the process of introducing water testing.

Equipment

The practice had appropriate equipment, medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise. We noted that the last recorded checks were made in January 2015. The practice had an Automated External Defibrillator (AED) (an AED is used in the emergency treatment of a person having a cardiac arrest).

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

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment completed on 30 January 2015 by a contactor were seen. Continual risk assessing took place in the different areas of the practice and we saw evidence of the assessments in the health and safety file.

Requires improvement

Are services safe?

Staffing and recruitment

The practice manager and GPs we spoke with told us that they felt the stable and experienced work force provided a safe environment for their patients. Staff at this practice worked as a team to cover the practice opening hours and would adjust their hours to cover any sickness or annual leave.

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included evidence of satisfactory conduct in previous employment and, where required, criminal record checks, using the Disclosure and Barring Service.

Newly appointed staff received an induction which included explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

We noted that many of the staff had been employed at the practice for several years and some of the files were not complete. We noted and staff confirmed that there had been improvements to the recruiting process since the new practice manager had started at the practice.

Monitoring safety and responding to risk

There were systems in place to identify and report risks within the practice. These included regular assessments and checks of clinical practice, medicines, equipment and the environment. We saw evidence that these checks were being carried out weekly, monthly and annually where applicable. Examples seen were the practice had carried out risk assessments for both legionella and fire safety.

Staff reported that they would always speak to the practice manager if an accident occurred and ensure that it was recorded. The accident book and all other practice policies were available to all staff at any time.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document had been updated In January 2015 following a power failure at the practice which had been dealt with appropriately. The policy also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The practice meetings covered various clinical issues, an example seen related to individualising new patient care; all new patients were offered new patient checks. Chronic disease management appointments were offered as appropriate, as well as GP appointments when required.

The practice had GP leads for chronic conditions, who acted as internal advice and referral within the practice. These GPs gave feedback on updates and courses through clinical meetings. Clinical audits and practice audits were proactively done as part of this process, alongside prescribing audits.

Regular annual review of medication and disease surveillance were offered through doctors and specialist Chronic obstructive pulmonary disease and diabetes lead nurses to encourage disease control and develop individual management plans. An example seen was the expertise to start insulin for Type 2 diabetes in the community and a named Diabetic Consultant for specialist advice

Management, monitoring and improving outcomes for people

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for areas such as the management of respiratory (breathing) disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice had a system in place for completing clinical audit cycles. The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. The practice carried out regular clinical audits to ensure the treatment they offered patients was in line with relevant guidance. There was evidence of learning from the audit process. Examples seen were a heart failure audit. This audit commenced in early 2014 with a follow up audit later in 2014. We saw that there were three stages of data collection followed by analysis and comparison. The audit resulted in the correct coding of patients and Installation of enhanced heart failure software to enable easy auditing of data to ensure an accurate heart failure register was maintained. Using the software system the practice could optimize treatment of those on the register. Ultimately audit outcomes were to see if there was a reduction in acute GP contact/hospital admissions which there was.

The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes. The practice had achieved 96.1% of the total QOF points for 2013-2014. This was against a practice average across England of 94.2%.

The practice used the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities, had a complete register available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed.

QOF is a system for the performance management and payment of GPs in the NHS in England, Wales, Scotland and Northern Ireland. It was introduced as part of the new general medical services contract in April 2004, replacing various other fee arrangements.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

The practice has three GP partners and a salaried GP who together worked an equivalent of three and a half full time staff. In total there were one male and two female GPs. The GPs were supported by two nursing staff and two health care assistants. The practice also had an administration team which consisted of receptionists, administrators, a secretary, a reception manager, IT manager and the practice manager. We observed all staff working professionally and there was a friendly atmosphere at the practice. Staff we spoke with told us that the staffing levels were suitable for the size of the service.

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

Staff we spoke with all told us they felt well supported by their colleagues and the practice manager. They said they had been supported to attend training courses to help them in their professional development and there was a culture of openness and communication at the practice and they felt comfortable to raise concerns or discuss ideas.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines. Those with extended roles seeing patients with long-term conditions such as diabetes, asthma and chronic disease management were also able to demonstrate that they had appropriate training to fulfil these roles.

GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council.

Working with colleagues and other services

The practice had regular meetings with the Integrated Care team involving the community matron (who has a virtual ward list of patients vulnerable to admission), district nurses, social worker and Community Psychiatric nurse. The aim was to discuss vulnerable patients in the community either through health, social or psychiatric issues, and try to formulate a combined plan of action. This helped identify patients who would benefit from Telehealth access at home, which allowed more regular communication with the community team, to improve health and avoid admissions. Telecare and telehealth services use technology to help patients live more independently at home. They include personal alarms and health monitoring devices.

There were quarterly Gold Standards Framework meetings to discuss new and existing patients with terminal or cancer diagnoses. This was a multidisciplinary meeting with the doctors, district and palliative care nurses, and the community matron. It was aimed at risk stratifying patients who needed immediate or potential end of life care. The minutes from this meeting were circulated to clinical staff.

An admission alert communication system had been established with Basingstoke and North Hampshire Hospital so that, upon admission, the surgery was notified immediately in order to share information, such as the care plan, at the most critical time.

The practice had a named geriatrician linked to the practice whom they could call on a hotline for advice.

Information sharing

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

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

The practice worked within the Gold Standard Framework for end of life care, where they provided a summary care record and EoLC information was shared with local care services and out of hour providers. For the most vulnerable, 2% of patients over 75 years of age, and patients with long term health conditions, information was shared routinely

Good

Are services effective?

(for example, treatment is effective)

with other health and social care providers through multi-disciplinary meetings which monitored patient welfare and provided the best outcomes for patients and their family.

Consent to care and treatment

We spoke with nurses who demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and a patients we spoke with confirmed that they understood about giving consent and did not feel pressured into agreeing to treatment. Examples found were a dedicated GP having one to one conversations with patients in a residential care home for patients with dementia to explain care plans and support them to understand.

If the GP or the nurse believed that the patient did not have capacity to consent in line with the Mental Capacity Act 2005, they discussed the matter with the next of kin, carer as well as fellow professionals in order to make a best interest decision for the patient.

Staff demonstrated an understanding of the Gillick and Fraser competence when asked about treating teenage patients. Gillick competence is a term is used in medical law to decide whether a child (16 years or younger) is able to consent to their own medical treatment, without the need for parental permission or knowledge. For example, when emergency contraception was requested.

Health promotion and prevention

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

There was a television in the waiting area which had a rolling programme of health promotion and prevention information including smoking cessation, flu vaccination and shingles vaccination. Patients who required support for drug addiction were directed to a local drugs addiction team.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, new patients were allocated to individual GPs who reviewed the records and took any action required particularly for vulnerable patients.

Information was available in easy to read formats and the practice had systems available on their web site for patients whose first language was not English.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice nurse.

Child immunisations were carried out regularly and non-attenders are notified to the health visiting service. The practice had achieved over 90% of its immunisation cohort of children. The practice held specific flu clinics to target at risk population groups, and orchestrated these vaccinations with the community team to provide cover for the housebound and nursing/residential home patients.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly to where they needed to be. The reception was accessible to patients with disabilities with lower desk height for wheelchair users. There were signs that asked for patients to respect the privacy of other patients. The practice had an area set aside for patients to use if they required further privacy to discuss any matter.

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

Data results showed that 97% of the proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as fairly good or very good. Patients told us that there were always treated with respect and dignity at the practice and this was also confirmed by the positive results seen in comments cards completed by patients.

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

Care planning and involvement in decisions about care and treatment

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

Patients told us that they felt listened to and involved in the decisions about the care and treatment. They expressed the view that they were given appropriate information and GPs took time to support and explain their care or treatment.

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

An NHS patient survey data also showed that 90% of respondents to the GP patient survey who stated that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care. The same survey also showed that 87.9% of respondents to the GP patient survey stated that the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care. Both of these figures were above the national average.

The practice had Identified 2% of their patients to put on a risk register. This was to ensure that emergency services, mental health and nursing home staff should be able to get through to a clinician in the practice within an hour in certain circumstances. Patients placed on the register had a named GP and a personalised care plan in place. Thereafter any patients added onto the register should be informed of their GP within three weeks and have a care plan in place within one month. The practice undertook monthly reviews of their risk register to check whether they needed to take any action to prevent unplanned admissions – for example on the basis of whether patients requiring multidisciplinary team input were receiving it, and whether the practice was receiving appropriate feedback from the district nurse team in order to agree an action plan for escalating care, including crisis management.

The practice told us that they had taken a positive approach in formulating the 2% of care plans with the patients. They improved communication with other health providers and had proven to be helpful in avoiding unnecessary admission and clarifying end of life wishes.

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room and patient website told people how to access a number of support groups and organisations. For example Hampshire's young people's service, a free confidential service for patients under 18 years who were experiencing problems with drugs, alcohol or solvents.

Good

Are services caring?

The practice identified patients with carers and sent information to those individuals to sign post support and services. The practice also offered an annual medical to carers, as they recognised them as a vulnerable group who often ignored their own health needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had worked with the patient participation group (PPG) to produce a practice survey for the wider practice population. The patient survey undertaken in 2014 showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice on the day of our visit.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. They had a shared care approach to dementia in nursing homes and the community. The practice actively identified patients with possible dementia and referred them through a dementia pathway to a multidisciplinary team.

The practice signposted patients suffering from depression to on-line and library self-help services, offered referral for counselling, and if required initiated medical treatment. The named GP approach supported those with chronic poor mental health and allowed for early recognition of deterioration.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the PPG. One example of this was introduction of SMS (text) appointment reminders as a result of feedback received from patients via the PPG. The most recent patient survey had taken place in December 2014 and 185 patients had responded. The analysis of the survey showed that the practice had improved significantly on access to GPs on the phone and the reception staff manner.

Tackling inequity and promoting equality

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

The practice was accessible to anyone who required level access. We saw disabled person's parking spaces close to the entrance door. A wheelchair accessible toilet was available and there was also a baby changing facility for mothers with babies to use. The reception desk was low in places which accommodated wheelchair users without them needing to move to a separate area. All the consulting rooms were on the ground floor and a lift was available for anyone who needed it to access the first floor.

Access to the service

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits, how to book appointments and contact the practice through the website or by telephone. 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.

Appointments were available from 8.30am to 6.30pm on weekdays. The practice offered appointments up to four weeks in advance and also on the day. The practice had specific protected appointments for children after school.

The dispensary was open Monday to Friday 8.30am to 6.00pm but closed between 1pm and 2pm. Routine surgeries were held Monday to Friday from 9.00am to 12 noon, 2.00 to 4.00pm & 3.30 to 5.30pm.

Extended hours were offered, for pre-booked appointments only, as follows: On the 2nd and 3rd Saturday of the month 9.00am to 12 noon. Tuesday 7.00 to 8.00am and alternate Wednesdays 7.00 to 8.00am.

Each day one of the GPs acted as duty GP and dealt with urgent appointments. The duty GP was either able to give telephone advice or offer five minute appointment slots for urgent issues. The GPs met every day after morning surgery to discuss patients and provide advice on care and treatment to each other. The GPs supported the duty GP by seeing urgent patients after they had completed their own appointments.

The practice nurses saw people by appointment for nursing matters such as vaccinations, cervical smears, suture removal, ear syringing and dressings.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Nurses ran clinics for chronic diseases such as asthma and chronic obstructive pulmonary disease. Patients were called back annually for a chronic disease review and the practice stressed to patients that it was important to make and keep these appointments.

The practice provided home visits, but asked that they only be requested for patients who were unable to attend the practice because of serious illness or infirmity, for example, for older patients and long term conditions. Requests for visits after 10.30am were dealt with by the duty GP.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a patient said that they had called in that morning for an emergency appointment and were seeing a GP within four hours.

For older people and people with long-term conditions longer appointments were made available when needed.

People whose circumstances made them vulnerable were supported to attend the practice and the practice worked towards understanding the needs of the most vulnerable in the practice population. Patients experiencing poor mental health within the practice population including hard to reach groups were offered longer appointments for those that needed them. The practice actively arranged further appointments ahead, at the time of consultation. This removed the barrier of access that could prohibit those with poor mental health seeing the doctor who knew them best.

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

The practice had a complaints policy and a procedure that set out how complaints would be addressed, who by, and the timeframes for responding. Both of these had been reviewed in December 2014. The procedure reflected the requirements of the NHS complaints process and included the details of external bodies for complainants to contact if they preferred. For example, the Care Quality Commission and NHS England ombudsman. This information was included in the practice information leaflet and on the practice website for patients.

Complaints were responded in a timely manner and audits were undertaken regularly to review the working procedures and practices which were amended where applicable. The complaints had been analysed to try and ensure that there were no repeats. The practice manager used the information to create learning points where required and these were fed back to staff for information.

The practice had a culture of openness and learning. Staff told us that they felt confident in raising issues and concerns. We saw that incidents were reported promptly and analysed. All complaints were discussed at meetings with the clinical staff; evidence of this was seen in the minutes from these meetings.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and there was openness and transparency in dealing with the compliant.

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 and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to their patients. These were displayed for patients in the waiting area and on the practice website. Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care.

There was a caring ethos of putting patients first that resulted from the GP leadership. Staff told us the practice had an open and democratic way of working to ensure that everybody felt part of the team.

The practice vision and values were included in the practice statement of purpose printed in the practice information booklet which gave the aims as providing effective, caring patient services to all registered patients while maintaining the work-life balance of GPs and staff. The main aims were to provide a high standard of integrated primary medical care to all patients that was closer to home and which met individual needs. To deliver services that are responsive to the needs of the local community and commissioners.

Governance arrangements

Governance arrangements were mostly effective. Practice staff were clear about what decisions they were required to make, knew what they were responsible for as well as being clear about the limits of their authority. The practice ensured that any risks to the delivery of high quality treatment were identified and mitigated before they became issues which adversely impact on the quality of care. We saw a number of practice protocols and policies. These were reference guides for nurses and GPs to use in the care of patients. Examples of protocols and policies seen were for complaints, recruitment and infection control. We saw that all the protocols and policies were available on the practice library which was available to staff on all the computers in the practice.

We did see that there may be some risks attached to medicines management in relation to key security for controlled drugs and prescription forms and standard operating procedures (SOP) for dealing with medicines, such as controlled drugs.

Leadership, openness and transparency

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

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at governance meetings and action plans were produced to maintain or improve outcomes.

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

The practice had a Patient Participation Group (PPG) and a Virtual Patients Representative Group (PRG) which was made up of a diverse range of patients. The PPG meet quarterly to review the findings from surveys and to discuss ways in which patient experience could be improved. The practice produced a newsletter, providing patients with updates such as changes to appointments and how to take part in the Friends and Family test. The PPG met on a regular basis and the results of the patient survey and action plans developed by the PPG were available on the practice website.

The practice had gathered feedback from patients through the National Patient Survey, PPG surveys and compliments and complaints. We saw that there was a robust complaints procedure in place, with details available for patients in the waiting area and on the website. We reviewed complaints made to the practice over the past twelve months and found they were fully investigated with actions and outcomes documented and learning shared with staff through team meetings.

All of the staff we spoke with told us they felt included in the running of the practice. They went on to tell us how the GPs and practice manager listened to their opinions and respected their knowledge and input at meetings. We were told that staff turnover and sickness was low and many staff had worked at the practice for over five years. Staff told us they felt valued and were proud to be part of the team.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. They also told us that regular appraisals took place.

From the summary of significant events we were provided with and speaking with staff we saw learning had taken place and improvements were made. The practice completed reviews of these and shared information with staff via meetings. Actions included how the practice could improve outcomes for patients.

Clinical audits were instigated from within the practice or from safety alerts received. We looked at several clinical audits and found they were well documented however not all demonstrated a full audit cycle.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found that the registered person had not protected people against the risk associated with the unsafe use and management of medicines. This was in breach of Regulation 13 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010. Which corresponds to Regulation 12 (1) and 12(2) (g) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 (Part3). How the regulation was not being met: Not all prescriptions were reviewed and signed by a GP before they were given to the patient. Fridge temperatures were recorded but we were unable to see historical records. Key security for controlled drugs and prescription forms were accessible by all staff entering the dispensary. Prescription security, serial numbers were not recorded. Standard operating procedures (SOP) for dealing with medicines were in place but some of the SOPs, especially for controlled drugs (CDs) were not complete as they needed to reflect the procedures at the practice. The registered person must protect service users against the risks associated with the unsafe use and management of medicines, by means of the making of appropriate arrangements for the obtaining, recording, handling, using, safe keeping, dispensing, safe administration and disposal of medicines used for the purposes of the regulated activity. Regulation 13 of the Health and Social Care act 2008 (Regulated Activities) Regulations 2010. Which relates to Regulation 12 (1) and 12(2) (g) of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014 (Part3).