Holdenhurst Road Surgery

Quality Report

199 Holdenhurst Road
Bournemouth
BH8 8DE
Tel: 01202 587111
Website: www.holdenhurstsurgery.co.uk

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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.

Summary of findings

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Summary of findings

Overall summary

Holdenhurst Road Surgery is a GP practice providing primary care services for people in Bournemouth. It offers a range of services including health screening, immunisations, and management of long term conditions. Local community teams support the GPs in provision of maternity and health visitor services. The practice has a total of nine GPs supported by a nursing team and an administration team for approximately 10,000 registered patients. Opening hours are between 08.30am to 6.30pm daily except Wednesdays when the practice opens at 07.30am. Outside normal surgery hours the emergency cover is provided by another service.

Holdenhurst Road Surgery has one location registered with CQC. This is at 199 Holdenhurst Road, Bournemouth BH8 8DE, where we carried out our announced inspection visit on 4 June 2014.

We spoke with 13 patients attending appointments on the day of our inspection. We also spoke with three patients from the Patients Response Group (PRG). This is a group of volunteer patients who have regular on line meetings, sometimes described as virtual meetings. They discuss the services on offer and how improvements can be made which benefit the patients and the practice. The members of the groups are self-selecting by responding to a patient survey. We received comments cards from one patient and emails from two other patients. We also spoke with GPs, nurses, reception and administration staff, and the practice manager who were working on the day of our inspection.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

We found the practice was pro-active about ensuring patients were safe. Significant events were recorded. These were shared within the practice as a means of learning, and improvements were made to ensure safety standards were maintained.

All staff had received training on safeguarding vulnerable adults and children. They were confident about what they needed to do if they suspected or were told about a patient being at risk or experiencing significant harm.

Overall the service was safe. However we found improvements were needed to ensure that the emergency medicines box had a checklist to readily identify what was in stock and hold necessary equipment and medicines in one place.

Are services effective?

We found the practice was effective in meeting the wide range of its patients' needs. There was a robust system in place to ensure the right skill mix and staffing levels were in place to provide an effective service at all times. Information about individual patients was shared with other healthcare providers such as the out of hours service, midwives and community nursing teams, and drug and alcohol services. Patients were provided with information leaflets about their health needs to support them in making decisions about treatment. They were also signposted to relevant agencies and services. This supported the continuity of the patient's care.

There were effective clinical governance systems in place. The quality of care and treatment was monitored by audits, spot checks, significant events learning, and patient feedback. There was a commitment to review and improve the effectiveness of treatment.

The majority of patients we spoke with told us the service met their healthcare needs with appropriate advice and treatment. We found that the practice worked with other agencies and multi-disciplinary working arrangements were in place. Appropriate information was shared with relevant parties such as local authority safeguarding teams, mental health professionals, substance misuse rehabilitation teams, and the local clinical commissioning group (CCG). The practice actively engaged with other service providers to ensure people received effective care.

Summary of findings

Are services caring?

We found the practice was providing a caring service. It recognised that the diverse range of its patient population meant there was a high and constant demand on its services. Patients' needs were met in a compassionate and caring manner. The practice achieved this by involving their patients in discussion about their health care, providing continuity of care as much as possible, and offering a holistic and patient-centred approach. GPs and nursing staff were opportunistic in undertaking routine health checks and screening. Patients were referred appropriately to other support and treatment services. The Out of Hours (OOH) service was notified of any pertinent information about individual patients in the event it was contacted by or about the patient. There were opportunities for people to provide feedback about the care and treatment they had received.

Are services responsive to people's needs?

People's individual needs were met without avoidable delay. Staff were aware of arrangements in place for responding to medical emergencies that may arise. There was an open culture within the practice with a clear complaints and feedback system in place. The practice involved people, their representatives and external agencies in planning its services, and routinely learned from patient experiences, concerns and complaints to improve the quality of care.

Are services well-led?

There were robust organisational structures in place with clear lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The practice promoted an open and fair culture.

The practice offered a service that was safe and of good quality through robust clinical governance and had systems in place to provide on-going monitoring.

New staff and trainee GPs received regular supervision opportunities to discuss their performance and issues relating to their role.

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

Holdenhurst Road Surgery had 400 patients over 75 years of age and a lower percentage of the practice population in the 65 and over age group than the clinical commissioning group (CCG) area and the England average. Overall the older people we spoke with were appreciative of the GPs and nurses. They felt they were treated in a professional and kindly manner. Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. They were able to refer people to local services such as dementia screening clinics and falls assessment clinics. Older patients were identified by practice staff on their patient record as "vulnerable", if, for example, there were physical and/or mental health issues. This meant practice staff were alerted and would be aware of any issues in the event of contact by or about the patient. This information was not routinely shared with other healthcare providers; this was based on individual circumstances and the reason for a referral

People with long-term conditions

Holdenhurst Road Surgery cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions.

Holdenhurst Road Surgery worked to the Quality Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. Holdenhurst Road Surgery achieved lower than the national average in relation to enhancing the quality of life for people with long term conditions, for example, the percentage of patients with coronary heart disease whose blood pressure readings were acceptable. Local factors which affected the practice's achievement included being located in an area where there was a high rate of unemployment and social deprivation and isolation. A significant number of patients were known to the practice who had drugs and or alcohol dependency. This meant that some patients tended to have chaotic lifestyles, and there was a regularly changing registered patient

population. Some patients did not consider their healthcare to be a priority. Nursing staff and GPs responded to this by being opportunistic about offering health screening checks to patients with long term conditions when they attended the practice.

The practice routinely carried out reviews, audits and checks to ensure patients with long term conditions were receiving the correct medicines. The practice followed best practice guidance to ensure it was meeting and protecting patients' medical needs and complying with other statutory guidance issued by, for example, the Department of Health.

Mothers, babies, children and young people

The majority of patients registered at Holdenhurst Road Surgery were under 50 years of age. A significant number of these were young mothers with babies and children. Maternity services were provided by the GPs and the locality midwifery team. There was also a specialist midwifery team who accepted GP referrals for pregnant women who were vulnerable and at risk of harm from sexual and or domestic abuse. This team worked closely with the health visitor team to ensure continuity of care after the baby was born. Children and mothers at risk were identified on their patient records.

The health visitors were based on the practice premises which meant they had regular contact with the GPs and practice nurses. They arranged appointments for child immunisation and these clinics were run weekly at the practice.

Effective systems were in place for GPs to seek advice and support if they had concerns about a child, and to raise a safeguarding alert with a place of safety if they felt the child was in immediate danger of harm. Practice staff were observant for signs of neglect. GPs and health visitors monitored these families with escalation to the relevant agencies as needed. They were also aware of the impact of poverty on patients and provided signposting information to various services.

The GPs provided family planning. Although there was not a high percentage of teenagers who were pregnant registered with the practice, there was a large proportion of young mothers and young women who were pregnant. The GPs offered "same day" appointments for emergency contraception. For women in early weeks of pregnancy, GPs provided care and support for those seeking a termination. Sexual health promotion was provided by the practice. A local sexual health clinic offered support and treatment to patients less than 25 years of age, however, patients had to meet high criteria to access this service. Other local sexual health clinics were more easily including another GP practice which offered a

genitourinary medicine (GUM) clinic specialising in sexual health and giving tests and treatment for many sexually transmitted diseases. Holdenhurst Road Surgery had a lower percentage of the practice population in the 18 and younger age group than the CCG area and England average.

The working-age population and those recently retired

The majority of the patient population registered at Holdenhurst Road Surgery was of working age. The practice tried to accommodate working patients' needs outside working hours. The practice provided longer opening hours from 8am to 6.30pm daily except Wednesdays when it was open from 7.30am. The patients of working age we spoke with considered a telephone call from a GP was generally as effective as a visit to the practice. They were also confident the GP would see them on the same day if this was necessary.

The nursing team provided routine blood tests and health screening as well as treatment for patients referred to them by the GPs.

Patients of working age who were considered or known to be at risk of significant harm were identified on their individual patient record.

The practice recognised the transient nature and diversity of its patient population most of whom were patients of working age. It had a good structure and governance systems in place to ensure it provided an effective, safe, responsive and caring service to meet the needs of these patients.

People in vulnerable circumstances who may have poor access to primary care

People in vulnerable circumstances who may have poor access to primary care were well supported by Holdenhurst Road Surgery. The majority of patients registered at the practice were under 50 years of age and high number of these patients were living in vulnerable circumstances. This included being homeless, at risk of sexual and or domestic violence, and with alcohol and or drug dependency. The nursing staff and GPs were able to refer patients to local drug and alcohol support services. There was also a tight control and overview by the practice staff and GPs on weekly prescriptions for people at risk of misusing their prescribed medicines. Other local services that worked closely with the practice offered, for example, sexual health clinics, and maternity care for vulnerable pregnant women.

More than 50% of the patients registered at Holdenhurst Road Surgery did not speak English as their first language. There were at

least seventeen different languages. Some GPs and nursing staff had specific language skills and patients were able to request appointments with them. A telephone transation service was available however this was not found to be an effective means of communicating with patients needing a translator. The GPs recognised that the lack of local translation services posed a risk with regard to ensuring non English speaking patients received appropriate and timely care and treatment. GPs and nursing staff were therefore pro-active in seeking ways to communicate with their patients to ensure they had sufficient information as well as consent for treatment. In most cases patients attended their appointments with a friend or a family member to help with translation. This was recorded on their patient record as well as confirmation of consent to disclose personal health information to the translator. We saw clinicians also used internet translation services.

People experiencing poor mental health

Holdenhurst Road Surgery was located in an area where housing was predominantly bedsitters, there was a high rate of unemployment and social deprivation. A significant number of patients misused drugs and or alcohol and many lived with anxiety and depression. The GPs offered support and treatment for patients of all ages experiencing mental ill health. They had access to a crisis intervention team and also referred people to appropriate local support services for assessment and treatment. Patients experiencing mental ill health were identified on their patient record. The mental health support services contact telephone numbers were included in the information pack for locum GPs working at the practice and individual GPs maintained their own lists of contact details. Trainee GPs or locums were expected to inform or discuss any concerns about the mental well-being of patients with senior GPs.

Summary of findings

What people who use the service say

The patients we spoke with were satisfied with their treatment and complimentary about the care and attention they received. They said GPs, GP trainees and nurses were kind and efficient.

We received some negative feedback about two receptionists who patients considered were rude. The practice manager told us that measures were in place to address and monitor individual staff behaviour and attitude. We also saw evidence of this in staff supervision records.

Six patients complained about the length of time they had to wait for a routine appointment. They told us it could be anything up to three weeks for a routine appointment. This resulted in people ringing the practice at 08.00am or queuing outside to be there for opening time in order to ask for a same-day or emergency appointment. Other patients told us they found it difficult to get through on the telephone because all the lines were busy and when they did get a response all the appointments were usually taken.

The practice manager told us and we saw that systems were in place to meet the demand for appointments. We also found it was a patient belief they had to call at 08.00am; there was no evidence to show patients had to do this and receptionists were trained that they must not advise patients to do this. The duty doctor for the day saw people needing urgent appointments, supported if necessary by another GP. Telephone triage was operated daily too. Most patients we spoke with were happy with the opportunity chance to speak with a doctor on the telephone.

Some patients told us the receptionists asked for some details about the reason for an appointment. We found a number of patients objected to these questions because they did not think it was appropriate. The practice manager explained the questions had been introduced as a means to signpost to the correct person – doctor, nurse, or doctor's telephone call. They also told us and we saw in the reception staff file, that reception staff were instructed not to insist that a patient gave a reason to see a GP.

The GPs had recognised that the local population had grown significantly and was predicted to grow by 12,000 over the next eight years. They had therefore agreed a merger with two other local practices. This was planned for April 2015 and initial stages of sourcing suitable alternative premises were underway.

Holdenhurst Road Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP, a practice manager, an expert by experience and a second CQC inspector.

Background to Holdenhurst Road Surgery

Holdenhurst Road Surgery provides care and treatment to about 10,000 patients. It is located in an area where housing is predominantly bedsits. The majority of patients registered at the practice are under 50 years of age. A high number of patients are living in vulnerable circumstances including being homeless, at risk of sexual and or domestic violence, and with alcohol and or drug addictions. Patient risk of being a victim or involved in violent crime is significantly worse in Bournemouth than the England average.

The practice supports a large number of families living in difficult situations with a significant number of children at risk of harm. The practice has a higher income deprivation affecting older people than the CCG area and England average.

About half of the patient population do not speak English. There is an increase in the student population resulting from an increase in provision of student housing. Holdenhurst Road Surgery staff acknowledged there was a struggle with the population growth locally and this was predicted to increase by a further 12,000 people over the next eight years. The practice capacity and demand were continually monitored by the GPs due to about 20% transience of the patient population.

Health profiles are designed to help local government and health services identify problems in their areas and decide how to tackle these issues. They provide a snapshot of the overall health of the local population and highlight potential differences against regional and national averages. Priorities in Bournemouth include the reduction of hip fractures, drug, alcohol and self-harm, malignant melanomas, and sexually transmitted diseases. We noted that statically the practice did not measure well in some areas for patient care and review. For example, Holdenhurst Road Surgery was rated as “much worse than expected” for measurement of hypertension and cholesterol. We found however that the practice had a transient patient population with an average of a 20% turnover annually. This meant that patients may have been diagnosed but never returned for health screening and monitoring because they had moved away from the practice.

Holdenhurst Rd Surgery was rated “better than expected” for consent sought before personal information was used in ways that did not directly contribute to the delivery of care services and objections to disclosure of confidential and personal information were appropriately respected. There was a leaflet informing patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. The practice also showed more “tending towards better than expected” for information governance training being provided for its entire staff.

The GP Patient Survey for Holdenhurst Rd Surgery results showed it was rated “worse than expected” for the receptionists at the surgery who were not found to be very helpful or helpful at all; and “better than expected” for surgery opening times that were convenient for patients.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Before the inspection site visit we reviewed a range of information that we had about the service. This included information from other organisations such as the local Healthwatch, NHS England and the Clinical Commissioning Group which shared with us what they knew about it. We reviewed comment cards that we had asked the provider to give out to people who used the service, so that people could share with us their views and experiences of the service.

We carried out an announced inspection visit on 4 June 2014 at the provider's registered location, 199 Holdenhurst Road, Bournemouth BH8 8DE. We spoke with the registered manager, the practice manager, GPs, nursing staff, administration and reception staff who were working on the day of our visit. We looked at the arrangements in place for monitoring presenting symptoms, diagnosis and treatment. We observed how the service handled telephone calls and patients arriving at the practice. We spoke with patients, other carers and or family members. We also met with three representatives of the Patient Reference Group (PRG). This group acted as voice for patients at the practice.

Are services safe?

Summary of findings

We found the practice was pro-active about ensuring patients were safe. Significant events were recorded. These were shared within the practice as a means of learning, and improvements were made to ensure safety standards were maintained.

All staff had received training on safeguarding vulnerable adults and children. They were confident about what they needed to do if they suspected or were told about a patient being at risk or experiencing significant harm.

Overall the service was safe. However we found improvements were needed to ensure that the emergency medicines box had a checklist to readily identify what was in stock and hold necessary equipment and medicines in one place.

Our findings

Safe patient care

The practice had robust systems in place to ensure that all clinical and medical staff were aware of risks within the practice. The practice was aware that a number of their patients lived in areas of social risk and poverty. The GPs met weekly with the practice manager to discuss all issues that had arisen including any serious and adverse incidents. Any decisions or new arrangements were discussed at staff meetings or emailed to all staff depending on the urgency.

Reception staff, trainee GPs and locums were able to seek support from the duty GP or senior GP in the event of concern about a patient. All staff and clinicians also had access to a "flash" message system whereby they could alert GPs of any immediate concerns. There was an emergency alert system for all staff in the event of an emergency or a staff member was concerned for their own safety. If triggered, it alerted all staff and identified where the incident was in the building.

The practice offered a chaperone service if people required intimate examinations. A chaperone is a member of staff who acts as a witness for a clinician and a patient during a medical examination or treatment. Patients also told us they could take someone, for example, a family member or friend, in with them.

GPs and nurses had access to good support services locally where they were able to refer patients for appropriate care and treatment, for example, a crisis intervention team for patients with escalating mental ill health, and support and treatment with drug and alcohol misuse.

The practice operated a robust system to ensure a tight control and overview by the practice staff and GPs on weekly prescriptions for people at risk of misusing their prescribed medicines.

The nurses' treatment rooms were clean and infection prevention control procedures were in place.

A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing. The practice had two nominated Caldicott Guardians which indicated that the practice took its responsibilities to protect confidentiality seriously. There was a leaflet informing

Are services safe?

patients how their information was used, who may have access to that information, and their own rights to see and obtain copies of their records. The practice also provided information governance training for its entire staff.

Learning from incidents

The practice maintained a log of significant event reporting and follow up. We saw seven events were recorded since March 2014 for the year 2014 -15. These included an incident occurring as a result of poor communication with the district nursing team with a meeting between the practice manager and district nurses to find how this could be improved. Also an incident arising because a patient had not understood what was being asked of them via a text message sent by the reception staff about a routine test. All staff were reminded they must endeavour to ensure patients receiving text messages would know what was being asked of them otherwise they should find an alternative method to communicate and explain.

Safeguarding

Everyone working at the practice had completed safeguarding training. Additional training was also provided by GPs to staff using examples of day to day events occurring within the practice. All the staff had access to up to date contact details which we saw with a clear flowchart of what to do in the event of a concern posted in every surgery, treatment room and the reception.

GPs and nurses also had training about the Mental Capacity Act 2005 and informed consent. If they had any queries or concerns about a patient's capacity to understand what they were being asked to do, they were able to seek advice and guidance from the GP Safeguarding Lead (adults and children). They could also consult another GP who was a section 12 approved doctor. This meant they had specific expertise in mental disorder and had received additional training under section 12 of the Mental Health Act (MHA) 1983. Section 12 of the MHA describes the measures which must be in place to protect the rights of those who, due to their mental health, may need to be detained or receive treatment against their will.

Monitoring safety and responding to risk

Patient records were marked with symbols to identify if they were considered to be vulnerable, for example, patients with a mental illness, dementia, at risk of domestic or sexual abuse, or a child at risk of harm. This was a means of alerting staff and clinicians in the event of contact by or about the patient.

The practice staff told us if there was a "no show", for baby immunisations they would contact the parent/guardian to find out why the appointment had been missed. This was recorded on the child's patient record. If there were any concerns about the reason for missing the appointment or if this recurred, the GP was made aware and could refer the matter to appropriate health professionals and social services if necessary. The practice worked closely with the health visitors and midwives with regards to children's safety. This showed the practice had measures in place to check the safety and wellbeing of children registered with the practice.

We found the practice had a similar system in place for people diagnosed with a mental illness. Patients were recalled for routine checks ups annually on their birthday. In addition if people with mental illness failed to attend appointments on three occasions following prompts and reminders, the local mental health team was contacted. If clinicians had major concerns they would alert the community psychiatric nurse (CPN to request a home visit. We found the practice nurse was very aware of their patients and those likely to be more vulnerable and at risk.

The practice had a system in place to formally review and learn from significant events. There were weekly GP meeting with the practice manager to discuss all issues arising from the previous week including significant incidents. There was formal partners' meetings held six weekly where practice business and complex cases were formally reviewed to ensure appropriate action had been taken. There were also multi-disciplinary meetings for GPs and nursing staff to consider clinical updates and issues arising in the practice. These meetings also included serious incidents.

Medicines management

Patients could request repeat prescriptions in person or online; although we found very few patients we asked were aware of the repeat prescription online system. We found the quality checks and systems in place within the practice were robust to recognise when the authorised number of repeats had passed. If this occurred the patient was informed and it was passed back to the named GP for review. There was also a tight control and overview by the practice staff and GPs on weekly prescriptions for people at risk of misusing their prescribed medicines. This ensured people's medicines were reviewed regularly. The repeat prescription template showed the patient's history and

Are services safe?

diagnosis attributed to each drug. Sensitivity could be added by the GP or nurse. Patients were given verbal information about medicines when they were initially prescribed. Each GP had a daily list to review of prescribing queries. The patient record system would issue a warning of interaction between drugs if a patient was on several different drugs. The clinical system was robust and the GPs utilised it to ensure patients safety and wellbeing.

The Dorset CCG produced a medicines formulary which was a guide for clinicians on the most appropriate medications to use for patients This guide and frequently used drugs were routinely discussed at partners meetings. Prescribing data from the Dorset CCG showed that compared with other practices, Holdenhurst Road Surgery was "average" in its prescribing. We found there was a higher rate of prescribing for medicines to manage epilepsy due to a high number of local care homes for people with learning disabilities.

GPs were pro-active in working with particular groups regarding their medication. For example, one of the GPs with a specialist interest in diabetes was working with a specialist diabetes nurse to increase treatment and prescribing of medicines to manage diabetes. The was particularly pertinent as the registered patient profile of the practice had a bulge of men aged between 30 to 50 years of age who were most at risk of diabetes.

Prescribing of statins was low due to the low numbers of older people registered with the practice. Due to a patient population with high levels of needs but a low level of interest in managing their own health, healthcare was not a priority which meant there was low prescribing for medicines to manage, for example, cholesterol.

The practice maintained a cold chain for vaccines. Prescriptions were stored in a lockable cupboard.

We found there was no list to check the emergency medicines. The emergency medicines and equipment box was lacking items including gloves, sharps box, razor and fluids.

Cleanliness and infection control

The practice had an infection control policy in place and it was up to date. There was also an infection control lead that oversaw and reviewed the procedures which were in place to reduce risks of infection. Hand sanitiser was in place around the building. We observed people were moved out of a waiting room after a patient was unwell. We saw staff knew where to locate the spillage kit and wore protective equipment. We also observed when a patient with an infectious condition arrived for their appointment, they were discreetly invited to wait in a separate waiting area to prevent risk of infection to other patients. All the areas we saw around the practice appeared visibly clean. We saw evidence of regular checks, audits and challenge of cleaners by the practice manager. The most recent example was the cleaner not closing the lids on clinical bins. The practice manager explained why this was important to the cleaning staff and continued to monitor it to ensure it was being done.

Instruments used for minor surgery were sent to the local hospital for sterilisation. They were kept in packs standardised across community and general hospitals. The practice followed clinical guidance published by the National Institute for Health and Care Excellence (NICE) in April 2013.

Staffing and recruitment

Patients were cared for by suitably qualified, skilled and experienced staff because the practice had completed the relevant checks on staff before they started work. There was a clear recruitment and selection policy, which was kept under regular review to ensure its contents, covered all of the standards as set out within the NHS employer's safer recruitment guidelines. We found that all relevant checks had been completed before staff started work at the practice, including checks with the Disclosure and Barring Service (previously known as Criminal Records Bureau) to help ensure that people who used the service were protected and safe. All the staff files we looked at had updated contracts containing terms and conditions of their employment. The provider had checked that GPs were included on the performers list, which showed their fitness to practise and clinicians' registrations with the General Medical Council and the Nursing and Midwifery Council to ensure they were up to date and had not expired.

Dealing with Emergencies

The practice had a contingency plan in place to deal with emergencies. The written plan included information on how to manage loss of computer systems, telephone systems, failure of services such as gas and electricity and what to do if any staff were incapacitated. It also included details of organisations to contact if any of this happened.

Are services safe?

The practiced manager advised us that interviews were being held for the appointment of a deputy practice manager who would deputise as key person in their absence.

Equipment

The practice had systems in place to monitor the safety and effectiveness of equipment. For example, fridge temperatures were taken and recorded to show that correct storage temperatures were maintained for vaccines and medicines. Effective checks were performed on oxygen, gases and the defibrillator. We saw all portable appliance testing, water safety, fire safety, lift maintenance and other equipment checks had been undertaken with appropriate certification and validation checks in place. A maintenance company was contracted to do general repair work. We saw evidence that repairs had been identified and action was being taken.

Are services effective?

(for example, treatment is effective)

Summary of findings

We found the practice was effective in meeting the wide range of its patients' needs. There was a robust system in place to ensure the right skill mix and staffing levels were in place to provide an effective service at all times. Information about individual patients was shared with other healthcare providers such as the out of hours service, midwives and community nursing teams, and drug and alcohol services. Patients were provided with information leaflets about their health needs to support them in making decisions about treatment. They were also signposted to relevant agencies and services. This supported the continuity of the patient's care.

There were effective clinical governance systems in place. The quality of care and treatment was monitored by audits, spot checks, significant events learning, and patient feedback. There was a commitment to review and improve the effectiveness of treatment.

The majority of patients we spoke with told us the service met their healthcare needs with appropriate advice and treatment. We found that the practice worked with other agencies and multi-disciplinary working arrangements were in place. Appropriate information was shared with relevant parties such as local authority safeguarding teams, mental health professionals, substance misuse rehabilitation teams, and the local clinical commissioning group (CCG). The practice actively engaged with other service providers to ensure people received effective care.

Our findings

Promoting best practice

Patients received care and treatment according to national guidance including guidelines from the National Institute for Health and Care Excellence (NICE) and best practice professional guidelines. Other examples included the Mental Capacity Act 2005 (MCA). The MCA is a framework which supports people who need help to make decisions. Staff were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. Clinicians were aware of consenting issues for children. Parents or guardians were asked to sign consent for babies. The practice did not have a policy for a minimal age to see a child alone however nurses and GPs were confident they would make a personal judgement of how capacity to make informed decisions applied to individual children. In the event of GPs or nurses being unsure if a patient who did not speak English had understood or had capacity to understand, they would seek a second opinion from a colleague. One GP said they had had two consultations where they considered it was not in the patient's best interest to continue due to language and translation difficulties so they had rebooked these appointments. Information about who was present during consultation and how translation was provided was always recorded on the patient's records. If the patient had a nominated representative, for example, for translation or because they were mentally frail, this was also recorded on the patient's record.

Management, monitoring and improving outcomes for people

The practice was organised with systems in place to monitor the effectiveness of the service it provided. There was a system was in place to formally review and learn from significant events. There were formal partners' meetings every six weeks where practice business and complex cases were formally reviewed to ensure appropriate action had been taken. There were also practice meetings for GPs and nursing staff to consider clinical updates and issues arising in the practice. Receptionist and administration staff had separate meetings, however, they would attend practice meetings if subjects relevant to their work were on the agenda.

Are services effective?

(for example, treatment is effective)

Staffing

The practice had five GP partners, one of whom was the senior partner. This meant they each held responsibility for the running of the practice and the senior partner had overall responsibility. There were also two part time salaried GPs who provided clinical assistance to the GP partners and two trainee GPs also known as GP registrars. These were doctors who were undertaking advanced training in general practice. The practice also offered two week placements for medical students two to three times each year.

The practice has a very clear structured induction with one, three and six months quality and competency check points. Annual appraisal and informal one to one meetings were in place. We looked at two staff appraisals and saw these discussed performance and what needed improvement. The practice also had a competency test in place for new staff. This was completed by the staff member and their mentor , and this was monitored and reviewed by the practice manager. We saw that the practice manager had recently made this more competency test more structured and staff feedback was that it worked well. We saw evidence of staff being provided with further informal training about the questions they asked patients in order to determine what appointment to book– GP, nurse or GP telephone call. Staff had been given clear explanations about why they should accept that people could refuse to tell them why they wanted an appointment. The practice employed apprentices as receptionists and they were supported by a mentor. Staff feedback was this was working well and they felt supported.

The nurses kept their personal development records and reflective notes for their individual portfolios. They undertook the training they needed to undertake their role and were up to date with their training. This included sourcing relevant training and attending in-house training. The nurses held clinical meetings each week and they used these to share training and knowledge between the team. Their annual appraisals were conducted by a GP on a rotational basis.

The GPs had internal and external networks of clinical support. They all had an annual appraisal which was conducted by other GPs who were recognised appraisers. A GP appraiser is responsible for checking GPs have kept up to date with their knowledge, and is someone who works elsewhere. The GPs partners also underwent a 360 degree review. This was an evaluation that included direct feedback from an employee's subordinates, peers, and manager(s) as well as a self-evaluation. It also included feedback from patients. The GPs used this information as part of their appraisal as well as for planning future development and learning. A record of evidence was kept for the appraisal and this showed details of continual professional development, including study days and individual learning. The appraisal also included quality improvement actions where the GP demonstrated their input into the profession, and discussion about any significant events, feedback from patients and colleagues, and looking at any complaints. The GPs were also preparing for or had already undergone the revalidation process. Revalidation is a requirement for all practising GPs, including locums, every five years to ensure they are meeting the requirements of their registration.

The practice operated a disciplinary process. We saw evidence of a robust action being taken by the practice and additional staff training was provided as result of an incident that breached staff terms and conditions of employment.

Working with other services

The practice worked with other healthcare providers to ensure that patients received effective care. We were given examples of when multidisciplinary meetings would be held when assessing a patient's capacity to give consent and to ensure decisions were made in the patient's best interest. We also saw evidence of effective working relationships with the crisis intervention team, and a local drug and alcohol support service.

Health visitors were based on the practice site and this enabled good communication between them and practice staff. Other local services that worked closely with the practice offered, for example, sexual health clinics, maternity care for vulnerable pregnant women, dementia screening and assessment, and falls assessment.

The practice had established links with the local safeguarding teams for both children and adults.

Health, promotion and prevention

Information leaflets were available in both waiting rooms. GPs also gave patients information leaflets during consultations if this was appropriate and this was recorded on the patient record.

Are services effective?

(for example, treatment is effective)

There were many notices and posters on a wide variety of subjects on the walls. The whole of one wall and the accessible parts of another were covered in notices and posters. However the effectiveness was limited by the sheer volume of posters. This made it difficult to readily identify specific information. Some notices were in small fonts which were difficult to read without leaning over waiting patients.

Patients were screened for HIV at the time of registration. Any and all medication they were taking at this time was also recorded on their patient record. There was routine healthcare monitoring and screening, for example, cervical screening and early detection of diabetes. Patients on weekly prescriptions for medicines such as diazepam and morphine were put on to reduction programmes as much as it was possible.

The local hospital maintained a list of patients who frequently attended A&E. This was shared with the practice. We found there was high attendance by patients of the practice. Staff told us this was due to a multi-cultural patient population that considered hospital to be the default for health care. GPs and other practice staff told us they worked hard with patients to educate them about using the practice in the first instance or calling the out of hours service if they needed medical advice out of opening times.

Are services caring?

Summary of findings

We found the practice was providing a caring service. It recognised that the diverse range of its patient population meant there was a high and constant demand on its services. Patients' needs were met in a compassionate and caring manner. The practice achieved this by involving their patients in discussion about their health care, providing continuity of care as much as possible, and offering a holistic and patient-centred approach. GPs and nursing staff were opportunistic in undertaking routine health checks and screening. Patients were referred appropriately to other support and treatment services. The Out of Hours (OOH) service was notified of any pertinent information about individual patients in the event it was contacted by or about the patient. There were opportunities for people to provide feedback about the care and treatment they had received.

Our findings

Respect, dignity, compassion and empathy

The practice waiting room and reception area on the ground floor was as discreet and spacious as possible. The reception desk was open in style, without a window or high level reception desk, so patients were able to see and speak directly with the reception staff. A tape barrier behind which waiting patients were asked to stay until they could be seen by the reception staff meant that patient privacy and confidentiality was respected. Telephone confidentiality was maintained by reception staff taking calls in the reception office screened from the reception desk. Reception staff were mindful of individual patient needs and health conditions. They took appropriate measures for example, to ensure patients likely to experience stress and raised anxiety were offered a quiet area to await their appointment. Patients presenting with infectious conditions were discreetly asked to wait in a separate area to avoid putting other patients at risk.

There was ramped access into the ground floor reception and waiting room, and a lift to the first floor waiting room and treatment rooms. This made access easier for people with mobility impairments and or parents with young children and babies in prams and buggies. We observed some patients were clearly having difficulty in hearing when GPs or nurses came in person and called them through; it was often quite noisy, and certain areas in the waiting room were at an angle and too obscured to be able to see staff. There was a hearing loop system, and one small sign with its logo was situated by the reception desk. There was no other signage in respect of the hearing loop.

The GP surgeries and nurses treatment rooms had curtains for screening and privacy when examinations were undertaken. The practice offered a chaperone service. A chaperone is a member of staff who acts as a witness for a clinician and a patient during a medical examination or treatment. Usually this was provided by one of the nursing team on request of a GP or if a patient wished this. On rare occasions if a nurse or healthcare assistant was not available reception staff were trained and able to for this. Discussion with staff found they did not go inside the curtain with the GP. In the event of a patient alleging an incident against the GP, this may not be deemed sufficient or adequate evidence that a chaperone was present at the time of the procedure or treatment.

Are services caring?

Involvement in decisions and consent

The feedback we received about patients experience of their healthcare was positive about the GPs and nurses. Practice staff cared for patients with long term conditions including asthma, diabetes, and heart disease. They provided child immunisation, travel vaccinations and phlebotomy (the process of taking blood). Maternity services were provided by the GPs and the locality midwifery teams. We saw examples of how consent was obtained and recorded on patient records.

Over half of the patients registered at the practice did not speak English as their first language. Some GPs and nursing staff had specific language skills and patients were able to request appointments with them. A telephone translation service was available however this was not found to be an effective means of communicating with patients needing a translator. The GPs recognised that the lack of local translation services posed a high risk with regard to ensuring non English speaking patients received appropriate and timely care and treatment. GPs and nursing staff were therefore as pro-active as possible in seeking ways to communicate with their patients to ensure they had sufficient information as well as consent for treatment.

We saw that systems were in place to make sure urgent and routine referral letters were triaged, written and sent promptly. People were able to telephone to find out about a referral or test results. Although checks were in place for third party requests for results (such as family members ringing to ask about test results) we observed not all reception staff knew this. The practice manager confirmed this would be monitored as part of mentoring.

We found that everyone working at the practice was expected to sign a confidentiality agreement as part of their contract of work. Generally people we asked were not concerned about confidentiality. They were aware their information may need to be shared by the GP or nurse with other healthcare professionals. All staff underwent training on information governance (sharing confidential information).

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

People's individual needs were met without avoidable delay. Staff were aware of arrangements in place for responding to medical emergencies that may arise. There was an open culture within the practice with a clear complaints and feedback system in place. The practice involved people, their representatives and external agencies in planning its services, and routinely learned from patient experiences, concerns and complaints to improve the quality of care.

Our findings

Responding to and meeting people's needs

We received positive feedback from patients about the clinical care and professionalism they had received from GPs and nurses. Apart from some complaints about receptionists who people felt had sometimes been abrupt, patients were satisfied with their treatment; in some cases delighted and very grateful. Three patients came to the practice specifically to tell us how good they considered Holdenhurst Road Surgery to be, and a fourth patient who was away at the time of the inspection, sent a complimentary email to us.

Two patients were very appreciative of the trainee GPs and commented about how they were up to date and knowledgeable. Nurses were universally praised as kind and effective. One patient praised the nursing staff for their frequent and successful treatment of varicose veins. One patient also spoke positively about the midwifery team.

Patients told us they felt they were involved in their care and treatment. They confirmed they had time to think about the options and felt able to ask questions if they were unsure about anything. People said they were offered additional information about their illness and other help and advice, for example, about smoking cessation.

Practice staff cared for patients with long term conditions including asthma, diabetes, and heart disease. They also provided child immunisation, travel vaccinations and phlebotomy (the process of taking blood). Maternity services were provided by the GPs and the locality midwifery team based at the hospital. There was also a specialist midwifery team that provided antenatal care to vulnerable pregnant women, for example, sex workers who were at risk of sexual violence, and women known to the practice to be at risk of domestic violence. These women had indicators on their patient records so, in the event of contact by or about the patient, practice staff would be alerted to ensure the patient was seen. The GPs also provided complex family planning and minor surgical procedures.

The health visitors used rooms in the practice as well as running children's clinics on the premises. This meant there was regular contact between the practice clinicians and the health visitors. Patients needing community nursing were referred to the district nurse team. The practice used a

Are services responsive to people's needs?

(for example, to feedback?)

message book to communicate with the district nurses as they were based elsewhere. Staff told us they felt communication with the district nurses was poor since they no longer shared premises and had changes of management structures. Patients needing physiotherapy were referred to the hospital physiotherapy team. GPs could also refer patients to other services such as support and treatment for drug and alcohol misuse, anxiety and depression, counselling, dementia screening and falls assessment.

We saw notices advising patients that self- testing kits were available on request to check for sexually transmitted diseases or they could see a practice nurse. Women could also request an urgent appointment for emergency contraception ("morning after pill") if they were within three days of being at risk of pregnancy. Nursing staff told us they were opportunistic about monitoring patient's health. They offered routine appointments rather than run specialist clinics for patients with long term conditions. They said this had improved and increased patient access and choice about when they attended appointments as they did not have to "fit in" with specialist clinic times and days.

We saw that systems were in place to make sure urgent and routine referral letters were triaged, written and sent promptly. There were also systems in place to follow up on, for example, blood tests, x-rays and scans, and letters from the hospital. The practice did not hold named doctor patient lists due to the transient patient population. Patients were able to request appointments with the same doctor unless it was an emergency and their preferred doctor was not available. This meant people received continuity of their care whenever it was possible.

Access to the service

Patients told us if they needed to see a GP there were urgent and emergency appointments available on the same day. They also said these were on a "first come first serve" basis which meant turning up and waiting to be seen. Patients complained to us about the length of time they had to wait for a routine appointment. They told us it could be anything up to three weeks for a routine appointment. This meant patients tended to call the practice at 8am to ask for a same-day or emergency appointment. Some patients treated these as entirely interchangeable. One patient told us they always told the receptionists it was an emergency in order to get an appointment without waiting. Another patient said that as they lived locally, they came in to the practice because it was easier to get an appointment at the desk. An older patient told us they tried to call the surgery at 8am but the lines were always busy, and all the appointments were gone by the time their call was answered. The same patient also pointed out that patients were already queuing outside before the practice opened. They felt they had little or no chance of an appointment on the same day by ringing from home.

Most patients, especially younger people, were not worried which GP or nurse they saw, but those with complicated and/or long-term conditions usually tried to see their preferred doctor. These patients were appreciative of the reception staff and told us they really helped patients who were regular and known to them. Additional evening appointments were available to assist people who were working. Analysis of these slots showed that although they were well used, it was not by the target group. One clinician told us it was not uncommon to have a mother attend a late appointment with their young child dressed in pyjamas because there had not been any appointments during the day.

In order to try to direct patients to the correct person – GP, nurse or GP telephone call, the receptionists asked patients for a brief description of their condition. They tried to avoid booking emergency slots for medical certificate renewals. Staff told us they tried to educate patients to request an appointment at least three days before their medical certificate ran out if they thought it needed to be reviewed. Most patients we spoke with told us they were happy with speaking to a doctor on the phone.

Every GP had an on-call/duty day. This was divided into half a day telephone triage and half a day of urgent appointments. They were supported by another GP. Children were always seen unless the parent requested a telephone call from the GP. We saw that the appointments system allowed all the GPs an overview of all the patients booked for the day. This meant they could help each other out if they noticed a colleague was running behind with their appointments. If a GP had too many patients waiting, they could also send a flash message to the other GPs requesting assistance to see patients.

The practice site was too small for the number of people who used it daily. We observed GPs and staff working in cramped conditions with access to four floors (including

Are services responsive to people's needs?

(for example, to feedback?)

converted loft space) via narrow staircases. The two patient waiting areas had bench-style seating in order to provide as much seating as possible. We observed both waiting areas still became crowded. Space was also restricted for parents/carers with buggies and prams. In spite of their working conditions GPs, nurses and reception staff maintained a holistic patient-centred approach to their care and treatment of people. The reception staff on duty were kindly, cheerful and efficient in a situation which could be very testing. We also observed that the staff and clinicians' management of patients from a diverse range of ethnic groups and nationalities, those with complex mental health, and a transient population, still retained the feel of a practice that was welcoming and cared about the health and wellbeing of it patients.

Concerns and complaints

We saw the surgery had a complaints policy in place and there were leaflets in both waiting rooms inviting patients to make complaints and comments. Reception staff told us they tried to deal with issues if patients complained at the desk however they would call the practice manager if a situation could not be resolved or was escalating. They told us they found it challenging when some patients demanded immediate repeat prescriptions or medical certificates. The reception staff said it was a lack of understanding despite trying to explain and educate patients that they needed to give a three day notice period for repeat medical certificates and prescriptions.

We saw evidence of online responses to NHS choices. Patients were offered the opportunity to discuss their complaints however the practice manager told us these offers were generally not taken up. The most common NHS choices complaint was about reception staff attitude. The practice manager told us how they had identified the staff members complained about and had addressed issues with them.. We saw evidence of on-going monitoring of general reception staff members and of individual staff performance . On the day of our inspection we also observed that one staff member whose performance was being monitored following a complaint managed a difficult situation in the reception area with great skill.

Are services well-led?

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

Summary of findings

There were robust organisational structures in place with clear lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The practice promoted an open and fair culture.

The practice offered a service that was safe and of good quality through robust clinical governance and had systems in place to provide on-going monitoring.

New staff and trainee GPs received regular supervision opportunities to discuss their performance and issues relating to their role.

Our findings

Leadership and culture

Staff told us they felt they were well supported and enjoyed working at the practice. They knew how to raise concerns although not all staff were aware about whistleblowing and where they would report their concerns. Regular meetings were held where GPs and the practice manager could share and discuss all information concerning the practice.

Governance arrangements

There were management systems in place to monitor the quality of the service provided. Regular reports were provided to the Dorset Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management. Referrals were monitored and there was a quarterly system in place for GPs to check each other referrals, for example, for appropriateness and timeliness.

We asked the practice how it ensured the right skill mix and staffing levels to provide a safe and effective service at all times. We found that all the reception staff multi-tasked and were able to do all the required daily tasks in line with their role. They also had their own areas of responsibility to ensure they had an additional interest, for example, scanning and coding new patient record summaries.

The practice manager undertook a daily capacity and demand count as well as planning for the next three to four months ahead. We were shown a log of the GPs annual leave. They were permitted to take ten days consecutively, something to which they had all agreed. We saw the pressure points were July and August, and these were highlighted. There was evidence of locums booked to cover these periods. Staff leave was operated on a fair system whereby the year was broken into quarters. Each quarter a different staff member had first pick. This operated on a rolling basis meaning that everyone always had an opportunity to take leave at times of their choice. They were also able to swap amongst themselves.

The practice did not use the NHS dashboard because it was not considered to be up to date. The practice manager told us about their involvement in a recent pilot for a similar tool which had more “live” data. We found the practice manager was very computer and IT literate and was able to make good use of a variety of audit tools for the benefit of the practice and its patients.

Are services well-led?

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

Systems to monitor and improve quality and improvement

Holdenhurst Road Surgery participants in the annual national Quality and Outcomes Framework (QOF). This is a nationally recognised voluntary annual reward and incentive programme for GP surgeries in England. The practice has to achieve targets called indicators in four main sections, called domains. These include clinical care which looks at long term conditions such as asthma and coronary heart disease to make sure the staff are caring for these patients adequately.

In the main QOF results were achieved by the practice. We noted that statically the practice did not measure well in some areas for patient care and review. For example, Holdenhurst Road Surgery was rated as "much worse than expected" for measurement of hypertension and cholesterol. We found however that the practice had a transient patient population with an average of a 20% turnover annually. This meant that patients may have been diagnosed but never returned for health screening and monitoring because they had moved away from the practice. The practice staff also told us that although patients were contacted when they were due for an annual review, for example, patients with diabetes and mental ill health such as depression, frequently they did not attend. The practice tried three times following a missed appointment to recall patients who did not attend. The practice staff said that non-attendance was due, in part, because a number of their patients lived in areas of social risk and poverty, and because of multiple languages and cultural views about health care. These factors meant patients did not always consider health checks were a priority. There had however been an increase in attendance for chronic obstructive pulmonary disease (COPD) reviews since the practice had employed a nurse with a diploma in the treatment of COPD. A community nurse specialising in diabetes also occasionally came in to the practice to provide a specialist clinic for patients with this condition.

Nurses and GPs told us they tried to be opportunistic if they saw a patient about one condition but recognised they had multiple long term conditions, for example, diabetes and a heart-related disease. We also saw examples of alerts on patient records that were available to the GPs and nurses. These prompted if reviews were due or overdue.

We found that as well as directed audits the practice undertook a variety of audits. These included prescribing, patient access to appointments, and telephony to ensure fast telephone answering was taking place. We saw an example of a recent spot check audit on access to patient records. This had identified an issue and robust action had been taken by the practice manager to address this.

We saw a formal analysis of significant events took place at the practice. This was done to highlight any trends. They were also used as a learning exercise for all staff and clinicians. A review of complaints also took place to monitor any areas where improvements could be made. We saw the responses to complaints were prompt and letters were written in an open non defensive style. We noted that minor concerns had also been reported as formal complaints. We were told this was to ensure all issues of concerns were addressed fairly.

Patient experience and involvement

The practice had a Patient Representation Group (PRG). This was virtual however it suited the patient population who were more readily able to access and use email and text messaging as an instant means of communication. The PRG acted as a patient voice and provided feedback to the practice manager and partners. Individual GP surveys were conducted as part of annual appraisals. The practice also monitored feedback via external sources such as NHS Choices.

Staff engagement and involvement

In addition to the general and departmental meetings, a number of other regular meetings took place dealing with business matters, personnel, complex care, and liaison meetings with other health care professionals. These were all minuted and available for staff. Checks were in place with each department to ensure a continuation of everything was carried forward each day as well as regular checks throughout each day.

Learning and improvement

We looked at a random selection of staff files. We saw they had received an annual appraisal where training needs were identified, present conduct discussed and future plans agreed upon. Nursing staff files contained evidence of professional training and reflection on specific issues. We saw that clinicians were appraised by clinicians and administration staff appraised by administration staff. This meant that competencies were assessed accurately by managers who were aware of the member of staff's role.

Are services well-led?

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

GPs had protected time learning time about four or five times per year. They maintained a record of evidence to showed details of the continual professional development which included study days and individual learning. Their appraisal included quality improvement actions where the GP

demonstrated their input into the profession and discussion of any significant events, feedback from patients and colleagues and looking at any complaints. We saw that appraisals had resulted in learning opportunities and changes in practice. For example, one GP shared with the other partners about good practice guidance that showed they did not undertake some minor surgery procedures in sufficient numbers to ensure procedures were safe and up to date. This had resulted in this GP deciding to withdraw from doing these minor procedures.

There was a locum GP induction in place and this was overseen by the practice manager. They were also responsible for arranging locum GP cover when this was required, although we were told this was only for short periods such as study leave or holidays. As far as possible the practice tried to use known locums to maintain continuity of patient care.

Information and guidance was offered to staff at the practice in the form of protocols and policies. These were available to all staff in the staff handbook found via the practice intranet.

All staff received training in basic life support and anaphylaxis annually. They also attended fire safety awareness training and safeguarding training. All staff were signed up to and understood the legal requirements they had to meet in order to comply with the Data Protection Act, and individual staff were appropriately trained for each criterion to meet information governance requirements.

Identification and management of risk

The practice had a business continuity plan. It had identified the rise in population and a future prediction for a further growth of 12,000 over eight years. Although the practice maintained an open list, it had decided to merge with another practice and its branch surgery. Both practices felt a merger would allow each to share best practice for a population with high needs. It would provide them for example, with a stronger audit team, and the different services offered at each practice would compliment the others.