Oakley and Overton Partnership

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	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 Overton Surgery part of the Oakley and Overton Partnership on 18 February 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, effective, caring, responsive and well led services to all population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, 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.
- The practice was a 'dementia friendly' practice. All staff had training in dementia to enable them to support patients with dementia and their families appropriately. One GP had successfully accessed additional funds to improve dementia services in the locality.
- The practice had worked with other organisations to launch a dementia befriending service for people living in the practice catchment area.
- 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.

The provider SHOULD:

Summary of findings

- Undertake a risk assessment to review the practice procedure for departmental authorisation of the administration of patient group directions.
- Ensure the infection control audit has an action plan to demonstrate areas identified for improvement have been acted upon.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

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 the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had undertaken specialist training to enable them to undertake extended role responsibilities. 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 patient centred support and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services. Data from the GP National Patients' Survey (2014 released January 2015) showed 97% of patients rated the practice very good or fairly good which was above the Clinical Commissioning Group average. Patients said all staff were respectful, helpful and understanding and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We saw staff communicated with patients with patience, kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. 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. Data from The GP National Patient Survey 2014/2015 suggested 98% of respondents found their last appointment convenient or fairly convenient. Overall the practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was

Summary of findings

available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders through team and practice meetings.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and values. Staff were clear about the values and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. Overall there were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

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

People with long term conditions

Good

The provider was rated as good for this population group . Nursing staff had roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. Patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The provider was rated as good for this population group. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The provider was rated as good for this population group. The practice had met all of the minimum QOF standards for monitoring patients with a learning disability including holding a register of patients with a learning disability. It had carried out annual health checks for all people with a learning disability and longer appointments were available.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The provider was rated as good for this population group. The practice had met standards for the monitoring of patients with dementia. The practice was identified as a 'dementia friendly' practice. All staff had training in dementia to enable them to support patients with dementia and their families appropriately. A GP partner was awarded a National Institute for Health and Care Excellence Fellowship and a successful joint bid to improve and fund dementia care in the locality including patients registered at the practice. Data indicated 94% of patients with poor mental health had a care plan. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including the Alzheimer Society and MIND (mental health charity).

Summary of findings

What people who use the service say

On the day of the inspection we spoke with eight patients two of whom were from the patient participation group. We looked at 38 CQC patient comment cards, the GP National Patient Survey 2014/2015, the NHS Choices Website and the practice survey carried out in 2013/2014

Patients we spoke with, patient comments cards and survey feedback we looked at demonstrated patients were highly satisfied with the care and treatment received. Staff were described as friendly, professional and efficient This was supported by feedback from the GP National Patient Survey 2014/2015 which indicated 98% and 87% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. Additionally 97% of respondents described their experience of the practice as fairly good or very good. Further comments indicated 95% of patients would recommend the practice to family and friends.

Patient feedback showed patients were included in their care decisions, able to ask questions of all staff and had treatment explained so they could make informed choices. Feedback from the GP National Patient Survey 2014/2015 indicated 85% of patients said the last GP they saw was good at involving them in decisions and 85% said the last nurse they saw was good at explaining tests and treatments. These results were slightly above the CCG average. Patients we spoke with and patient feedback cards felt their privacy and dignity were respected. However, this was not supported by information from the CQC information management data review of the GP National Survey 2013/2014 which indicated some patients were not satisfied about the level of confidentiality in the waiting/reception area.

Feedback from the GP National Patient Survey 2014/2015 indicated 98% of patients said their last appointment was convenient for them which was above the CCG average.

Patients told us generally appointments were usually available with a preferred GP within five to seven days. This feedback was confirmed by the practice survey 2013/2014 which indicated 69% of participants who provided a response agreed they were usually able to see a GP of choice within five days.

All of the patient feedback on the day of the inspection told us patients were able to see a GP on the day of need if their appointment was urgent. This was confirmed by the practice survey which demonstrated 93% of those respondents who had needed an urgent appointment were able to see a GP. Most patient feedback (73% respondents GP National Survey) suggested the average wait in the surgery after their scheduled appointment time was generally five to 15 minutes.

Patients we spoke with were not aware of the complaint process even though there was information available in the practice. They expressed confidence in the practice to address concerns when they were raised.

Patients told us they were satisfied with the cleanliness of the practice.

Areas for improvement

Action the service SHOULD take to improve

The provider SHOULD:

- Undertake a risk assessment to review the practice procedure for departmental authorisation of the administration of patient group directions.
- Ensure the infection control audit has an action plan to demonstrate areas identified for improvement have been acted upon.

Oakley and Overton Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Additional inspection team members were a practice manager specialist advisor.

Background to Oakley and Overton Partnership

As part of the inspection we visited the Overton Surgery, Station Road, Overton, Hampshire, RG25 3DU. Overton Surgery has a branch surgery the Oakley Surgery, Sanfoin Lane, Oakley RG23 7HZ which was not visited during the inspection. Both surgeries make up the Oakley and Overton Partnership. The practice is part of the North Hampshire Clinical Commissioning Group.

The Oakley and Overton Partnership is a semi-rural, teaching practice with two sites which provide primary care services to residents in the towns of Oakley and Overton and surrounding villages. Patients can attend either of the two surgeries to access services. The Oakley and Overton Partnership has a population of approximately 11,164 patients of which a majority are of working age. The Overton practice houses the main administrative services for both sites. Maternity and community care practitioners provided by Southern Health are also based on the premises. All patient services are located on the ground floor of the Overton building.

The practice has three female and three male GP partners. They employ one salaried GP, four nurses, four health care assistants, a practice manager and reception/ administration staff. Most staff work part-time. GPs, nurses and health care assistants work across both sites.

The Overton Surgery is open Monday to Friday from 8.00am to 6.30pm. Early morning booked appointments are available on Tuesdays from 7.30am and an evening clinic on Thursdays from 6.30pm to 7.40pm. The Oakley practice is open Monday, Tuesday, Thursday and Friday from 8.00am to 5.30pm with lunchtime closing between 12.30 pm to 2pm. It is open on Wednesdays from 8.00am to 1pm. Early morning booked appointments are available at the Oakley Practice on Wednesdays from 7.30am. The practice has opted out of the Out of Hours primary care provision. This is provided by Hantsdoc.

Why we carried out this inspection

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.

Detailed findings

How we carried out this inspection

Before our inspection, we reviewed a range of information we held about the practice and asked other organisations, such as the North Hampshire Clinical Commissioning Group and the local Healthwatch to share what they knew.

We carried out an announced inspection on the 18 February 2015. During the inspection we spoke with six GPs, three nursing staff, three healthcare assistants, the practice manager, administration and reception staff. We spoke with eight patients who used the service. We looked at CQC patient comment cards. We observed how staff talked with patients.

We looked at those practice documents that were available such as policies, meeting minutes and quality assurance data as evidence to support what patients told us.

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.

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 patients' needs?
- Is it well-led?

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as complaints received from patients. Patient safety alerts were emailed to staff as they were received by the practice. We saw evidence staff had acted appropriately in response to the alerts for example, by contacting patients prescribed medicines which had been recalled by the pharmaceutical company. Although there was evidence to demonstrate staff we spoke with had read the alerts there was not a formal system in place to monitor that staff had read the information.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were 25 records of significant events that had occurred during 2014 and we reviewed a sample of these. There was evidence the practice had learned from these reviews. For example, changes to electronic record keeping to include review prompt dates.

Patient safety alerts, significant events and safeguarding concerns were a standing item on monthly clinical meetings attended by the GPs and nurses. Staff told us complaints and significant events were also raised at whole practice meetings every three months, via team meetings and as a yearly presentation to all staff. We saw evidence to confirm this. Minutes of the meetings were available to staff for information. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. There was a system to highlight vulnerable patients and their families on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example, children subject to child protection plans or families with a history of domestic abuse. There were bi monthly meetings with the health visitors and other relevant agencies. Shared care records and patient electronic health records were updated. We looked at three patient records with a GP to corroborate the information we had been given. Records confirmed the process worked in practice.

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke with were aware who the leads were and who to speak with in the practice if they had a safeguarding concern.

There were notices in all patient areas advising patients about requesting a chaperone (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). Staff undertaking chaperone duties had knowledge of the practice chaperone procedure. The practice had risk assessed whether staff who chaperoned required Disclosure and Barring Services (DBS) criminal records checks. We saw in the practice chaperone policy that staff without a DBS would not be left alone with patients and for this reason did not require any additional checks.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

Good

Are services safe?

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place procedures that set out how they were managed. The GPs were responsible for the management of controlled medicines. We saw controlled medicines records were accurate. The medicines were stored in a controlled drugs cupboard and access to them was restricted with the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The repeat prescribing procedure protected patients from risk. The practice had recently moved to electronic prescribing. Both paper and electronic prescriptions were still in use. Storage and recording of blank prescription forms followed the NHS Protect security of prescription guidance.

We saw the PGDs were up to date. (PGDs are written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Nurses had departmental authorisation of the PGDs by a designated person from the practice (the practice manager). Staff told us they were up to date with annual immunisation training in line with national guidance and legal requirements. Health care assistants only administered medicines under a patient specific direction in line with national guidance and legal requirements.

A member of the nursing staff was qualified as an independent prescriber and she received support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

We saw there was a system in place for the management of high risk medicines which may have put patients health at risk such as methotrexate (for treatment of arthritis) and warfarin (used to thin blood), which included regular monitoring in line with national guidance. Evidence from medicines audits indicated that these medicines were regularly reviewed to ensure patients were prescribed the appropriate medicine such as changes from warfarin to other blood thinning agents. In addition there were alerts for patients to attend for a medicines review when repeat prescriptions required updating and no further prescriptions were to be issued.

We looked at prescribing data from the Quality and Outcomes Framework (QOF) and saw the practice was in line with the national prescribing pattern for antibiotic, hypnotics and anti-inflammatory medicines.

Cleanliness and infection control

The practice had processes to protect patients from the risk of infection. We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept which were reviewed by the practice manager on a weekly basis. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had completed a comprehensive infection control audit in December 2014. There were a limited number of items to address. For example, the environment audit scored 83% identifying the main issue as chairs in consulting rooms not being wipe clean in line with national guidance. On the day of the inspection we found the practice had not started to address the issues and the documentation presented did not include an action plan for when improvements were to be made.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy.

Notices about hand hygiene techniques were displayed in treatment areas and staff and patient toilets. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms. Sharps disposal boxes were stored safely.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments.

We found the monitoring, testing and maintenance of equipment was regularly carried out based on a risk assessment.

Staffing and recruitment

Good

Are services safe?

The practice had processes to enable the recruitment of appropriately qualified staff. There was a clear recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

The practice maintained a spreadsheet which showed that all relevant staff had Disclosure and Barring Service (DBS) checks. We looked at two staff files which contained evidence that recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks through the DBS. The practice had engaged the services of a human resources advisory company and as a result all staff had an employee handbook including terms and conditions of employment and some policies such as whistleblowing and confidentiality. The handbook had been updated when amendments were required.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The lead practice nurse had recently retired and some staff expressed concern there were no plans to replace the person. The GP we asked told us the situation was under review and they were aware of staff concerns.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see.

We found equipment had been tested and calibrated in line with the practice risk assessment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Nurses and GPs told us they had annual basic life support training in line with national guidance. Other staff had attended basic life support training within the last three years appropriate to their roles. Emergency equipment was available for example, oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). Emergency medicines were available in a secure area of the practice. Staff knew of the location of the emergency equipment. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Records confirmed that emergency equipment was checked regularly. Staff gave us an example of how a respiratory arrest (cessation of breathing) in a child was managed successfully. As a result of the event a paediatric pulse oximeter (measurement of oxygen levels for children) was purchased for the practice.

A business continuity plan was in place to deal with a range of emergencies that impacted on the daily operation of the practice. Risks identified included flood risk, power failure and adverse weather. The document also contained relevant contact details for staff to refer to.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used a range of interventions to promote effective needs assessment. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from other research reports. For example, care pathways and management of a range of other clinical conditions such as high temperature in children. Practice care templates had hyperlinks to NICE guidance. These were reviewed and updated regularly. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, the use of care pathways and care plans for patients with long term conditions such as heart and respiratory disease.

The use of guidance prompted clinical audit and reviews of clinical guidelines for example, the management of patients with atrial fibrillation (irregularity of the heart beat). There were regular audits on the effectiveness of cervical smear screening, a quarterly review of histology results from minor surgery to ensure results had been received and actioned. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure each patient received support to achieve the best health outcome for them.

GPs and nurses met monthly to discuss patients with long term conditions who had been admitted to hospital, or had not attended for appointments or reviews. We noted these meetings also provided opportunities for staff updates for example, the use of electrocardiograms (monitors heart rhythm) or inhalers (respiratory conditions). In addition there were monthly meetings with the multidisciplinary members such as community nurses to review frail patients at risk of admission to hospital or who had end of life care needs.

The practice used a risk stratification tool to identify 2% of their most vulnerable patients who were at an increased risk of being admitted to hospital inappropriately.

Personalised care plans had been developed to enable the support and treatment for patients identified as at risk. Patients admitted to hospital were followed up on discharge within a specified period of time.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Parents of children who had attended A&E for respiratory (breathing difficulties) problems were also contacted to review their child's treatment.

GPs told us they lead in specialist clinical areas such as respiratory disease and womens' health. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Each of the practice nurses had a lead role in the management and support for long term conditions such as diabetes and respiratory conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

We looked at data from the local clinical commissioning group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national two week standards for the referral of cancer patients.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to review the services provided.

The practice had a system in place for completing clinical audit cycles. The practice had completed 12 clinical audits in 2014. Following each clinical audit, changes to treatment

Good

Are services effective?

(for example, treatment is effective)

or care were made where needed. There were three audits which had been repeated to ensure outcomes for patients had improved and plans to re-audit others. A number of the audits were related to safe medicines management.

One clinical audit reviewed the number of patients prescribed a specific antibiotic identified as unsuitable for some patients with diminished kidney function. The review was in response to guidance from the Medicines and Healthcare Products Regulatory Agency. There were 22 patients to who had diminished kidney function. These patients were contacted and reviewed by their GP and as a result some patients had their medicines stopped or changed to an alternative medicine. A template to enable accurate monitoring and consistent recording was set up and used in patients electronic health records. The audit was repeated to ensure the guidance was consistently followed. The re-audit identified there were fewer patients on the medicine and those patients that were taking it continued to be regularly monitored.

Another audit reviewed the place of death of patients. The main aim of the audit was to assess whether completion of an electronic template to record details of a patient's place of death prompted GPs to ask patients at end of life about their preferred place of care/ death. Evidence suggests that most dying patients would prefer to die at home yet most deaths occur in hospital. (End of Life Care Strategy 2008) The initial audit in 2010 demonstrated 44% of practice patients died in hospital. The audit was repeated in 2012 and 2014 and identified there was a decrease in hospital deaths (34% and 25% respectively) and an increase in hospice deaths. The audit identified that GPs continued to complete the template and recorded patients' end of life care preferences to enable their wishes to be respected.

The practice also used the information collected for the Quality and Outcomes Framework (QOF) (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, for example diabetes and implementing preventative measures. The results are published annually) and performance against national screening programmes to monitor outcomes for patients. The practice achieved 98.7% overall in the QOF minimum standards for 2013/2014 which was just above the CCG average.

There was a protocol for repeat prescribing which was in line with national guidance. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines. These included patient safety alerts as well as specific considerations for particular medicines for example; blood thinning medicines and those for the treatment of certain mental health conditions. There had been an audit undertaken in 2014 to set up an alert on patients' electronic records if they were prescribed more than 10 medicines. This prompted GPs to consider the impact of further prescribing, interaction between certain medicines and a plan to reduce medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice supported patients with long term conditions by offering advice and support through specialist clinics, screening and evidence based information. Routine health checks were completed for long-term conditions such as diabetes and respiratory conditions. QOF data 2013/2014 demonstrated 73.9 % of patients with asthma and 95.9% of patients with chronic obstructive airways disease had a review in the preceding 12 months. Care management was co-ordinated through multi-professional meetings with health and care professionals involved in their care.

The practice had implemented the Gold Standards Framework for end of life care. It had a palliative care register and met and worked with other health care professionals monthly to discuss the care and support needs of patients and their families.

GPs participated in an enhanced service for checking new-borns. This involved undertaking a clinical examination of all babies born at home within 24 hours of birth. Ongoing maternity services were provided in partnership with the community midwifery services.

The practice supported patients experiencing poor mental health by regular monitoring of their treatment and support needs. For example, 94% (QOF 2013/2014) of patients with serious mental health issues had a care plan documented in their records. Monitoring of patients wellbeing was above average for the CCG.

Effective staffing

Staff had the appropriate skills and experience to undertake their roles. Practice staffing included medical, nursing, managerial and administrative staff. We found the practice staff training records were generally well maintained particularly with regard to staffs continuing professional development education and training.

Good

Are services effective?

(for example, treatment is effective)

Information regarding mandatory training was also recorded but needed more details for example, specific dates of attendance. The records we looked at demonstrated that staff had attended mandatory training such as basic life support, information governance, health and safety and fire training and infection control updates.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. Role responsibilities included extended roles such as asthma and diabetes reviews and insulin initiation. (supporting patient transition from oral diabetic medicines to insulin treatment). One member of staff was undertaking a degree module in the history taking and physical assessment of patients to develop their role and aid in triage.

We noted a good skill mix among the GPs, with a number having additional training such as dementia care, minor surgery and interests in long term conditions and womens' health. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We were told all staff had annual appraisals that reviewed staff training including mandatory training undertaken and this was confirmed by information included in staff files we looked at.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the NHS 111 service both electronically and by post. Following a significant event review specific administration time was allocated each morning to ensure all correspondence was appropriately managed. The GPs who saw these documents and results were responsible for the action required. All staff we spoke with understood their roles and felt the system now in place worked well.

The practice was commissioned for an enhanced service (enhanced services require an enhanced level of service provision above what is normally required under the core GP contract) to support frail patients to avoid admission to hospital and stay at home. The GPs worked with the multidisciplinary team to develop and review patient care plans to meet the changing needs of these patients. There was a process in place to follow up patients discharged from hospital within a specified period of time.

The practice worked with a range of other agencies to support vulnerable patients and those at risk. The practice held monthly, minuted multidisciplinary team meetings to discuss the needs of complex patients. For example, those with end of life care needs or who had been admitted to hospital. Bi-monthly meetings were held with the health visitor to children on the at risk register.

The GPs told us they worked in partnership with local mental health services and met monthly with community mental nurses and regularly referred patients to local psychological support services.

Decisions about care planning were documented in a shared care record.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data and care plans to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, for example, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice was also 'live' in the implementation of the electronic Summary Care Record (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record (Emis) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that GPs and nurses applied the principles of the Mental Capacity Act 2005 to their practice area. All staff had training in dementia care which included information regarding mental capacity and competence assessments. We saw from patient records we reviewed with GPs that patients diagnosed with dementia were contacted to give permission for the practice to contact their carer if necessary.

Patients with a learning disability and those with dementia were supported to make decisions about their care and treatment. When interviewed, staff gave examples of how to enable patients to make informed decisions. For example, double length appointments and checking patients understood the treatment they were to have by explaining in treatment options in language that the patient could understand. Staff understood the principles of acting in a patient's best interest.

Nurses and GPs demonstrated an understanding of Gillick competencies (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions) and a duty of confidentiality to children and young adults.

The practice had a process to obtain written consent from patients prior to minor surgery undertaken at the surgery. Records confirmed the process was consistently followed. Consent for other procedures was also recorded on the patients electronic care record.

Health promotion and prevention

The practice had systems to monitor the health requirements of the practice population. For example, NHS Health Checks offered to all its patients aged 40 to 74 years. The practice kept a register of all patients with a learning disability and dementia. All patients with a learning disability were offered a health review with the practice nurse.

The practice had strategies to enable patients to take responsibility for their own health when they were able. There was a range of health promotion information in the practice and links on the practice website for all patient groups. In addition there was comprehensive health education information in the quarterly practice newsletter about topics such as immunisations and long term conditions.

There was a blood pressure self-monitoring machine and weighing scales in the practice. Patients would take their blood pressure, hand the results in for their GP to review and were followed up if necessary. Patients were offered support for smoking cessation and weight management through clinics offered at the practice. Free screening kits for chlamydia (a sexually transmitted disease) were also available for under 25's.

The practice's performance for cervical smear uptake was 84.4%, (National Intelligence Cancer Network 2014) which was above the Clinical Commissioning Group (CCG) average. Performance for breast and bowel cancer screening was similar or above the average for the CCG (National Cancer Intelligence Network 2014 74.7% and 60.4 % respectively).

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Practice data indicated 79% of patients over 65 years had a flu immunisation in 2014/2015. Last year's performance for all childhood immunisations was equal or above average for the CCG. There was a protocol to follow up non-attenders.

Patients who did not attend for health checks, reviews or follow up appointments were contacted to arrange for another appointment where nurses or GPs were concerned about their wellbeing.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This was data from the GP National Patient Survey 2014/2015, feedback from CQC patient comment cards and information from the practice survey 2013/2014.

We received 38 completed CQC patient feedback cards and spoke to eight patients (two of whom were from the Patient Participation Group). All patient feedback about staff was positive. They were described as caring, professional and helpful. This was supported by feedback from the GP National Patient Survey which indicated 98% and 87% of the practice respondents said the last GP and nurse (respectively) they saw treated them with care and concern. Additionally 97% of respondents described their experience of the practice as fairly good or very good with a further 95% of patients saying they would recommend the practice to family and friends. Patients we spoke with felt their privacy and dignity were respected. We observed a number of examples of patient, respectful and kind caring interactions with patients by staff.

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

On the day of the inspection we observed the waiting area and reception/booking in desk were in close proximity and did not easily afford privacy and confidentiality. This was supported by information from the CQC information management data review of information from the GP National Patient Survey 2013/2014 which indicated some patients were not satisfied about the level of confidentiality in the waiting/reception area. We found staff were discrete in their conversations with patients to respect patient confidentiality. We saw there was a separate room available on request if patients wanted to share confidential information.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the GP National Patient Survey 2014/2015 showed 85% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were slightly above the clinical commissioning group average. This was confirmed by patients we spoke with on the day of our inspection.

Staff we spoke with gave practical examples of how patients were involved in their care. For example, when commencing insulin patients were shown and then observed in giving their own insulin. They were contacted regularly for feedback on their progress in administering and monitoring their treatment.

Patients with dementia and their carers were supported to complete the 'This is me document' (Alzheimer Society) to inform others involved in their care about their care routines and likes and dislikes.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

Information in the patient waiting room, and patient website directed patients to a range of support groups and organisations. We were given an example of how GPs worked in partnership with mental health services to enable an older patient with dementia to spend Christmas in their own home. Another example demonstrated how a patient with addiction issues was supported to develop an action plan to improve their quality of life starting with learning computer skills.

The practice's computer system alerted GPs if a patient was also a carer. There were over 200 patients registered as carers. We saw there was information in the practice and on the practice website available to enable carers to understand avenues of support available to them. Carers were emailed to invite them for the annual flu injection.

Staff told us that if families had suffered a bereavement their GP would contact them. A note was placed on

Good

Are services caring?

bereaved carers electronic records to inform staff of their bereavement. In addition one GP gave patients and their families a mobile phone number to access additional support more readily.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to the needs of the practice population and had systems in place to maintain the level of service provided. The Oakley and Overton Partnership had a population of approximately 11,164 patients of which a majority were of working age.

Patients were able to access later evening and earlier morning appointments to fit in around work commitments. Evidence demonstrated patients were usually able to get timely urgent and routine appointments. The GPs offered telephone consultations in every surgery and communicated via SMS text messaging. Patients did not have to come into the practice to make an appointment or request a repeat prescription which could be done online. Frail, older patients were offered double appointments with a named GP.

The practice had undertaken 70 minor operations and 94 Joint injections in 2014 reducing referrals to hospital and improving waiting times.

Patients had access to specific treatment and support at the practice rather than having to attend hospital. For example, spirometry (to diagnose and monitor lung conditions, and a patient's response to treatment) and self-monitoring of blood pressure and weight. Seven patients were supported through insulin initiation (transfer from oral medicines to insulin for diabetes) during 2014. Patients with a range of physical and mental health conditions had access to regular health reviews, screening and monitoring.

Systems were in place for identifying and following-up children who were at risk. There were formal arrangements in place to liaise with health visitors and midwives when there were concerns about patients and families at risk. There were additional meetings with other members of the multi-disciplinary team to discuss patients at risk of admission to hospital, patients at end of life and those with mental health conditions.

Immunisation rates were generally equal to or above the clinical commissioning group (CCG) average for all standard childhood immunisations. Patients told us and we saw evidence children and young people were treated in an age appropriate way and recognised as individuals. The premises were suitable for children and babies. Patients under the age of 25 had access to screening for chlamydia (a sexually transmitted disease) without having to see a GP first.

The practice was a dementia friendly practice. Most staff had dementia awareness training to enable them to appropriately support patients with dementia and their carers. There were 115 patients on the dementia register who had access to longer appointments and a review. QOF data (2013/2014) indicated 89.2% of patients with dementia had a face to face review within the preceding 12 months.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice held a register of patients with learning disabilities and one for patients with dementia. The practice was a dementia friendly practice demonstrated through staff awareness of patient's needs. Working with other organisations the practice had recently launched a dementia befriending service for people with dementia living in the practice catchment area. There was not yet evidence of its full impact.

Longer appointments for patients with learning disabilities and patients with dementia could be arranged in recognition of the time needed to involve patients in their care and treatment. Patients over the age of 75 years had a named GP to enable continuity of care.

Patient services were situated on the ground floor of the building. The waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. There was an induction hearing loop for patients with hearing impairment. Accessible toilet facilities were available for all patients attending the practice, baby changing facilities were also provided.

The practice had access to online and telephone translation services for patients where English was not the patient's first language.

Access to the service

The Overton Surgery was open five days of the week. Monday to Friday from 8.00am to 6.30pm. Early morning booked appointments were available on Tuesdays from 7.30am and an evening clinic on Thursdays from 6.30pm to 7.40pm. Patients were able to book and cancel

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments in person, by telephone and online. Repeat prescriptions could be requested online, by post or in person. GP appointments were confirmed by text with patient permission.

Patient feedback indicated they were generally satisfied with the appointments system. Information from The GP National Patient Survey 2014/2015 indicated 98% of respondents were satisfied or fairly satisfied with their last appointment (above the CCG average). Patients told us generally appointments were usually available with a preferred GP within five to seven days. The practice survey 2013/2014 indicated 69% of participants who provided a response agreed they were usually able to see a GP of choice within five days although 21% of patients did not agree with this.

Patients requiring an on the day appointment contacted the practice and were called back by the duty GP who determined whether they required a face to face or telephone consultation or an appointment with the practice nurses. All of the patient feedback on the day of the inspection told us patients were able to see a GP on the day of need if their appointment was urgent. This was confirmed by the practice survey which demonstrated 93% of those respondents who had needed an urgent appointment were able to see a GP. Most patient feedback (73% of respondents GP National Survey 2014/2015) suggested the average wait in the practice after their appointment was five to 15 minutes however, 23% waited longer than 15 minutes. This was identified as an area for improvement by comments from patients in the practice survey 2013/2014 although patients commented that they themselves valued extra time when it was needed. The practice offered a range of appointments of different lengths to enable patients to have the time they required and to avoid undue waits after scheduled appointment times.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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 in the practice leaflet and website.

The practice supported a local care home and a named GP undertook a weekly 'ward round' to review patients' treatment and care needs. Home visits were arranged at the beginning of the day to ensure any potential admissions to hospital or access to services were managed in a timely way.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.

We saw that information was available to help patients understand the complaints system. Although patients we spoke with were not aware of the process to follow if they wished to make a complaint they said they felt able to report concerns and had confidence the practice would manage them appropriately. None of the patients we spoke with on the day of the inspection had made a complaint about the practice.

The practice reviewed complaints at weekly practice meetings and team meetings. There were 16 complaints recorded in 2014. There were no recurring themes in the complaints recorded. Of the sample of complaints we looked at they were comprehensively documented and demonstrated learning had taken place.

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 values and were aware of future challenges to the practice for example the ageing population. The main values were 'to provide high quality medical care delivered by a friendly, motivated team'. We found these values were printed in the practice patient information leaflet and were available to staff. We saw and read of examples of how these values were reflected in practice. We observed staff communication was caring and thoughtful, patient feedback demonstrated a high level of satisfaction.

The practice had influence with regards to the locality needs. Two GPs were involved at Clinical Commissioning Group level as leads for example, in diabetes and one GP partner was awarded a National Institute for Health and Care Excellence Fellowship and had successfully competed for a joint bid to improve and fund dementia care in the locality including patients registered at the practice.

Governance arrangements GPs

There was a clear leadership structure which had named members of staff in lead roles. For example, there was a nurse with lead responsibilities for safeguarding and GPs had lead responsibilities in safeguarding and medicines. We saw there had been learning from significant events which had resulted in, for example, increased administration time to allow for processing correspondence from other providers of healthcare. Minutes from the monthly governance meetings with the GP partners identified issues arising from other meetings such as significant event analyses and complaints in addition to other governance issues.

There were clear systems to improve communication internally and externally. Most communication was shared through regular minuted meetings. We were told the GPs met informally on a daily basis to peer review patient referrals and discuss immediate patient concerns. In addition they met monthly with the nurses to discuss clinical issues, review significant events and update on clinical education such as the management of diabetes. There were a range of other meetings with the multidisciplinary team and quarterly whole practice meetings.

The practice had policies and procedures in place for staff to govern activity and these were available to staff. We looked at a range of policies in recruitment, safeguarding. These were up to date and there was a scheduled review date.

The practice had a schedule to assess and update practice risk assessments. They had appropriate contractors to manage calibration and testing. Overall, the monitoring of external contract work was consistent such as cleaning and waste disposal.

The practice used the Quality and Outcomes Framework (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, for example diabetes and implementing preventative measures. The results are published annually to measure their performance). The QOF data for this practice showed it was performing above national standards.

The practice had governance procedures in place to ensure the completion of clinical audit cycles and We saw that the practice had undertaken 12 clinical audits in 2014 with three full audit cycles to demonstrate the effectiveness of the changes made. For example, the management of patients with kidney disease taking a specific antibiotic and a review of place of death to promote awareness of completing the template and recording end of life decisions.

Leadership, openness and transparency

Staff we spoke with told us that overall there was an open culture within the practice and they enjoyed working there.

Staff we spoke with were clear about their own roles and responsibilities. They told us they were well supported and knew who to go to in the practice with any concerns. They were happy to raise issues for meetings and were generally were well informed of practice issues via individual team meetings, meeting minutes and other practice meetings.

Staff had access to on-going professional development opportunities and regular appraisal. We saw evidence staff had progressed to other roles for example, from working in reception to a phlebotomist role.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy and management of sickness) which were in place to support

Are services well-led?

Good

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

staff. We saw a staff handbook that was available to all staff, which included sections on capability and harassment and bullying at work. Staff we spoke with knew where to find policies if required.

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

The practice had gathered feedback from patients through patient surveys, complaints and the patient participation group. The practice had an active patient participation group (PPG) of 19 which met with practice representatives every six months. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. They demonstrated the practice had responded to feedback from patients. For example, an improved text messaging service.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Evidence gathered throughout our inspection through staff interviews and record and policy reviews indicated overall the management team led through learning and improvement. For example, there were a range of audits, completed audit cycles and some in the process of re-audit. However, the action plan for the infection control audit required completion. Records of meetings, significant events and complaints were available as a resource for staff.

Staff told us and training records confirmed staff were able to remain updated with mandatory training requirements. We saw continuing professional development opportunities were supported through recognised programmes of study as well as in-house training. Staff files we looked at demonstrated annual appraisal took place which included a personal development plan. New staff were supported via an induction programme and specific support to orientate and train them for their role.

The practice was a training practice for foundation year two doctors (newly qualified doctors undertaking further training) and GP registrars working towards specialising in general practice.