Dr R W Shelly & Partners

Quality Report

Stokewood 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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Stokewood Surgery, Fair Oak Road, Fair Oak, Hampshire, SO50 8AU on 18 November 2014. Overall the practice is rated as good.

This practice has a branch surgery at Old Anchor Surgery, Riverside, Bishopstoke. Eastleigh. SO50 6LQ. We did not inspect the branch surgery.

We found that Stokewood Surgery is a good practice overall with a strategy and track record of continuous improvement for care and responded to the needs of patients living in the area. The practice was rated as good in the population groups we looked at.

Our key findings were as follows:

- Patients were complimentary about the care and support they received from staff.
- Staff told us they were committed to providing a service that put patients first.
- The practice responded to the changing needs of the different populations groups that used the practice.
- The practice had undertaken major internal refurbishment of the ground floor.
- The practice joined the Wessex GP Educational Trust in 2012. The Wessex GP Educational Trust (WGPET) was formed in 1990 to provide funding for educational events run by GP Tutors. It continues to fund a wide range of events from one hour lectures to week-long refresher courses throughout the Wessex Deanery.
- The partners have weekly meetings with the community care team and community matron.
- The practice was above the national average for satisfaction with phone access, opening hours and reported good overall experience of making an appointment.
- The practice showed good child immunisation percentages, which were above the percentage receiving vaccinations across the rest of the Clinical Commissioning Group.
- The practice showed a better than average result in areas such as maintaining a register of all patients in need of palliative care or support irrespective of age and maintaining a register of patients aged 18 or over with learning disabilities.

Summary of findings

We saw areas of outstanding practice including:

•The practice employed a medicines adviser who worked closely with patients and pharmacists to improve efficiency in prescribing.

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 people safe.

The premises were clean and well-maintained. Entry and exit to and from the reception and waiting areas were all on one level. The equipment and the environment were maintained appropriately and staff followed suitable infection control practices.

Vaccines, medicines and prescriptions kept on the premises were stored suitably and securely. There were suitable systems for the receipt, storage, record and administration of vaccines.

The practice had suitable arrangements in place for dealing with emergency situations and we saw policies in relation to reacting to any interruption to the service provided.

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 (NICE) and used it routinely. People'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 received training appropriate to their roles and any further training needs have been identified and planned for. The practice could identify all appraisals and the personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they were able 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. The practice shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. 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 practice had an active patient participation group.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed 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 dementia and end of life care. It was responsive to the needs of older people, and offered home visits. The practice had good care planning and support for local nursing homes. The practice also recognised the need to support carers and families with older people.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and were offered a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. 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. 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. One of the GPs had attended a number of meetings at a local youth centre to discuss health issues.

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for patients with a learning disability and these patients had received a follow-up. It offered longer appointments for people with a learning disability. All patients in this population group were offered personal care plans which were updated regularly.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia.

Summary of findings

What people who use the service say

During our visit we spoke with seven patients, including some members of the Patient Participation Group (PPG) and reviewed 43 comments cards from patients who had visited the practice in the previous two weeks. The feedback we received was positive. Patients were complimentary about the practice staff team and the care and treatment they received. Patients told us that they were not rushed, that the appointments system was effective and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive. We received some negative replies mainly around the appointments system and length of time it took for the telephones to be answered. We spoke with the practice about this and they were aware and were addressing these matters.

Outstanding practice

The practice employed a medicines adviser who worked closely with patients and pharmacists to improve efficiency in prescribing.

Dr R W Shelly & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP and a specialist advisor practice manager.

Background to Dr R W Shelly & Partners

Dr Shelly & Partners, Stokewood Surgery, Fair Oak Road, Fair Oak, Hampshire, SO50 8AU, has been based in Fair Oak on its current site for over 30 years providing medical services to the population of Fair Oak, Bishopstoke, Horton Heath and outskirts of Colden Common. The partnership holds a Personal Medical Services (PMS) agreement which was first set up in 2004, enabling the practice to offer additional services above and beyond a General Medical Services contract (GMS).

PMS is a locally-agreed alternative to GMS for providers of general practice. Legislation has allowed for PMS since 1997, but it is only in recent years that the number of practices choosing PMS has grown rapidly.

The defining feature of PMS agreements is their local nature. Unlike GMS contracts, they are negotiated between the primary care organisation and the practice, and are not subject to direct national negotiations between the Department of Health and the General Practitioners Committee of the BMA.

The practice joined the Wessex GP Educational Trust in 2012 and at the time of our visit had six doctors, two female and four male. All the consulting rooms and waiting areas afforded good access for patients who were disabled. The practice had approximately 17,000 patients on its list.

Out of Hours urgent medical care is provided when the practice is closed from 7.00 pm to 8 am, Monday to Fridays. From 6.30pm Fridays and all day and night at the weekends and public holidays.

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.

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.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the practice to send us

Detailed findings

information about themselves, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 18 November 2014.

During our visit we spoke with a range of staff including GPs, practice nurses, the practice manager, administration staff and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

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

• Older people

• People with long-term conditions

• Families, children and young people

• Working age people (including those recently retired and students)

• People living in vulnerable circumstances

• People experiencing poor mental health (including people with dementia)

This practice shows that the patient age distribution is above the England average for males and females in the 40-70 age groups. The practice indicators show that the average male life expectancy is 80.8 years and female 84.6 years. This practice is shown in the least deprived decile.

Public Health England data showed that 89.5% of patients would recommend the practice. The practice was above the national average for satisfaction with phones access, opening hours and reported good overall experience of making an appointment.

The practice showed good child immunisation percentages, which were above the percentage receiving vaccinations across the rest of the CCG.

The practice showed a better than average result in areas such as maintaining a register of all patients in need of palliative care or support irrespective of age and maintaining a register of patients aged 18 or over with learning disabilities. The practice held regular multidisciplinary case review meetings where all patients on the palliative care register were discussed.

Good

Are services safe?

Our findings

Safe Track Record

The registered manager and senior GP worked closely with the practice manager on governance at the practice and monitored incidents, near misses and significant events. The practice GPs met on a regular basis to discuss safe care of patients. Any learning points were discussed openly and any actions were taken and system changes were made where appropriate. We discussed clinical audits and looked at examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not. We saw evidence of reflection at the end of the full cycle, regardless of whether the desired change was achieved not.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points. An example seen where systems within the practice had been changed to minimise further risks, was a seriously unwell child who waited 20 minutes to be seen, the parent did not realise how unwell the child was. As a result the protocol for children waiting was changed and the duty nurse would be alerted as soon as a child patient arrived and would make a decision as to whether the duty doctor needed to see the patient immediately.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding of children and adults had taken part in specific high level three training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have.

The practice had a whistleblowing policy which staff were aware of and they understood what actions they could take if they had any concerns.

The practice offered patients the services of a chaperone during examinations if required. (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) We saw that details of this service were displayed around the practice building for patients to read and staff told that this service was offered to patients.

Medicines Management

Arrangements were in place in relation to the management of medicines at the practice. These included safe storage, records and disposal.

The practice maintained a log of fridge temperature checks which were recorded daily during practice opening hours. Staff were aware of protocols to follow if the fridge temperature was not maintained suitably. We saw that the medicines cupboard and the vaccines refrigerator in the nurse's treatment rooms were securely locked.

We checked the emergency medicines kit and found that all the medicines were in date. There was a log maintained with the expiry dates of all the medicines available in the kit. The vaccinations were stored in suitable fridges at the practice. All the medicines and vaccines that we checked were within their expiry date.

The practice employed a medicines adviser who had experience of working within a pharmacy. This person ensured that prescription records were kept up to date following hospital appointments or admissions. There was continual liaison with patients, doctors and local pharmacies to check that medicines were taken properly, for example educating and supporting vulnerable patients with the use of compliance aids. The manager worked with local pharmacy teams to explore ways of checking that the most appropriate and cost effective medicines were prescribed. Patients who took several medicines were also assisted in managing their repeat prescriptions to ensure they had an adequate supply.

The medicines manager co-ordinated the medicines alerts the practice received to ensure current guidance was followed. Other aspects of their role included providing

advice on travel vaccines and advising local care homes on medicines management. Prescription pads were securely kept in a locked cupboard within a designated area of the practice.

Within the practice the medicines manager advised the GP's and nurses and assisted with regular audits and reviews of the prescriptions of people with long term conditions. An example seen was a patient who was on numerous medicines and was unable to afford the prescription charges. The manager picked up that the patient was not ordering all the medicines prescribed. The manager highlighted this to the GP and the patient was given information that meant they were able to apply for benefits for prescription charges and be able to receive all medicines prescribed.

Cleanliness & Infection Control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The premises and especially the nurses' treatment room appeared very clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with prominently displayed notices with information on infection control and had clean privacy curtains, sharps boxes and pedal operated waste bins. We spoke with one of the nurses who clearly described the procedures in place to maintain a clean and safe working environment.

Hand washing guides were available above all sinks both in clinical and patient areas. There was a good supply of bacterial soap pump dispensers and paper hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was good segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Equipment

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

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

Staff had taken part in emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice. This training had been used when a patient arrested in a side room and was successfully resuscitated using the AED. A letter was received from the ambulance service expressing thanks for clinical care and staff support given to the ambulance crew and this was recorded as a positive significant event.

Staffing & Recruitment

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included evidence of satisfactory conduct in previous employment, and where required criminal record checks, using the Disclosure and Barring Service. Newly appointed staff received an induction which included an explanation of their roles and responsibilities and access to relevant information about the practice including policies and procedures.

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

Monitoring Safety & Responding to Risk

Risk assessments were carried out for safety in the practice and emergency procedures were carried out such as fire alarm testing and evacuation procedures. Changes to risk were monitored and responded to as and when required.

The practice conduct regular fire drills to ensure fire safety was high. Fire risk and Legionella assessments were carried out and seen to be satisfactory. Equipment testing and fire extinguisher testing were up to date.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The meetings covered various clinical issues, an example seen was in regards to individualising new patient care; all new patients were offered new patient checks. Chronic disease management appointments were offered as appropriate.

The practices had taken steps to prepare for the future with major internal refurbishment of the ground floor of the premises due to an increase in housing development in the catchment area.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. The practice carried out regular clinical audits to ensure the treatment they offered patients was in line with relevant guidance. There was evidence of learning from the audit process.

The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes. The practice used to the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities, had a complete register of available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed. Child antenatal clinics were run by midwives and any problems were referred to the GPs.

Effective staffing

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults, training in infection control and basic life support skills.

Staff told us they had received appropriate training and how much they enjoyed their variety of work. Staff said that they felt well supported by their colleagues and the practice manager. Staff felt comfortable to raise concerns or discuss ideas and received supervision and an annual appraisal of their performance.

Working with colleagues and other services

The provider worked in co-operation with other services and there was evidence of good multi-disciplinary team working. An example seen was working with a local community care team and community matron the practice assisted and provided a good level of service to housebound patients. The practice received a domiciliary phlebotomy service from the local hospital for up to 10 patients a week.

In November 2014 the practice started having multidisciplinary meetings and their first full meeting involved the community care team, health visitors, midwives and social services.

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement of other social and healthcare professionals especially in the care of older patients.

A retinopathy van visited the practice and used the car park area to see patients. The diabetic retinopathy screening service offered free annual screening for all diabetics over the age of 12 years. Diabetes the most common cause of blindness in the UK working population which makes screening very important. The service operated across South West Hampshire and the Isle of Wight using mobile screening vans which visited various GP surgeries.

Community diabetic services ran educational meetings from the practice for the local community.

Information Sharing

Where required, information was shared in a responsible and comprehensive way. An example seen was that care plans for vulnerable were shared and uploaded from the practice system to ambulance and Out of Hours providers.

Good

Are services effective?

(for example, treatment is effective)

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

Consent to care and treatment

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

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

Health Promotion & Prevention

Information was available in the waiting area although we were told that the practice was still replacing information after the refurbishment of the waiting area had been completed.

We saw that the November 2014 the practice known locally as Stokewood surgery had a newsletter that contained comprehensive health promotion and prevention information.

The practice offered Chlamydia screening and had taken part in a contraception initiative aimed at teenagers which encompassed the Gillick principles of consent. This test was used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

The practice midwives ran a local young mothers group for pregnant teenagers and one of the GPs had attended a number of meetings at a local youth centre to discuss health issues.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly to where they needed to go. There were signs that asked for patients to respect the privacy of other patients. The practice had a room set aside for patients to use if they required further privacy to discuss any matter.

Although the receptionist took phone calls at the desk, confidentiality was maintained as at no time did they mention any name or diagnosis or treatment.

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

Care planning and involvement in decisions about care and treatment

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

Patients told us that they felt listened to and involved in the decisions about the care and treatment. Patients expressed their views and were involved in making decisions about their care and treatment. Patients were given appropriate information and support regarding their care or treatment.

Patients told us that the doctors took time to explain things to them. Patients said they had the opportunity to ask additional questions if they needed to and felt their concerns were listened to.

The practice identified all vulnerable groups and offered personal care plans which were updated regularly and included medication use and wishes of patients at end of life.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

The practice provided emotional support in all the population groups. An example seen related to a number of patients who formerly worked in the railway industry. These patients had a relatively high prevalence of chronic obstructive pulmonary disease (COPD) and other respiratory disease. The practice supported these patients by nurse led chronic disease clinics and GP support.

Nurses provided support to patients; examples seen were of a nurse supporting an elderly patient with hearing problems to explain how to control their diabetes. Also of a nurse speaking with a young person angry that they had type one diabetes and supporting them to control and live with their diabetes.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had a patient participation group and worked with them to produce a practice survey for the wider practice population. The patient survey undertaken at the end of 2013 showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice on the day of our visit.

Child immunisations appointments were arranged in line with national guidance and non-attenders were notified to the health visiting service. The practice is achieving more than 90% of its immunisation cohort. The practice had regular meetings with their health visitors and regularly reviewed and discussed the needs of vulnerable families.

The practice worked closely with local nursing homes and the practice received a domiciliary phlebotomy service from the local hospital for up to 10 patients a week.

The practice had introduced a sit and wait clinic for patients so that they could be seen according to their needs.

The practice had instigated a programme to deliver annual health checks for a number of patients with learning disabilities. These patients had findings and recommendations incorporated into their personal care plans.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. There was a system in place for flagging whether a patient was at risk of abuse.

GP services were provided to local care homes on an individual patient basis. Three of the partners were liaison GPs for two local care homes and provided weekly ward rounds in the homes.

For patients whose first language was not English, the practice had access to online and telephone translation services.

The practice was situated in a purpose built premises which provided adequate access requirements for disabled patients. All consulting rooms were on the ground floor. The practice had recently completed a Disability Discrimination Act 1995 audit of the building. This audit identified several areas which could be improved, for example the introduction of a hearing loop system and further staff training in awareness of challenges encountered by disabled patients. The reception was accessible to patients with disabilities with lower desk height for wheelchair users

Access to the service

The practice had responded to patient concerns about difficulty in contacting the practice to make appointments. During the last two years due to prolonged periods of absence of partners and shortage of locums there had been a reduction in routine appointments. Wait times for appointments were continually monitored and the practice was auditing access and demands for appointments in order to try and provide a better service for patients.

At the time of inspection the practice offered the following; opening hours at the practice were 8.00 am to 7.00pm Mondays to Thursdays. 8.00am to 6.30pm Fridays and the practice was open on the first Saturday of the month.

All consultations were by appointment and the practice offered an online booking service. To register for these service patients were asked to email or telephone the surgery, or a 24 hour automated telephone service. Patients could book, check or cancel their appointment using this system. The appointments were in 10 minutes slots for one patient at a time. A separate appointment could be made for each patient attending.

Appointment options available were:

A 10 minute appointment with patient's usual doctor. A five minute booked telephone consultation, normally with patient's usual doctor but may be duty doctor if required same day.

Patients requiring a same day appointment, who fitted set criteria, would be offered a time slot to attend the sit and wait clinic. In order to meet the demand for same day urgent appointments, the practice was running a sit and wait clinic for invited patients. Patients who were unable to wait for the appointment date offered, and met the criteria, for a same day appointment, were offered a time to attend this clinic.

Patients were invited at timed intervals and the practice aimed to see patients within 60 minutes of their arrival (within the slot time allocated). The service was not a

Good

Are services responsive to people's needs?

(for example, to feedback?)

walk-in clinic, patients were required to ring so that an assessment could be made and an appropriate appointment offered. A record of patients invited to attend was kept.

Urgent telephone advice was given either by the duty nurse or duty doctor. Patients were asked the nature of the problem and for a telephone number so that the practice could arrange a call back. The practice also offered telephone consultations with the patient's usual doctor and these could be booked in advance as for routine consultations.

Patients requiring assistance outside the surgery hours were directed to the Out of Hours provider.

The premises and services had been adapted to meet the needs of patients with disabilities. The reception area had been designed to have lower levels for patients in wheelchairs or on mobility scooters to be able to speak with the receptionist at the same level. All the corridors were wide enough for wheelchair users and there were accessible toilet facilities.

Listening and learning from concerns & complaints

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

Complaints received by the practice were responded to in a timely manner. Audits were undertaken regularly to monitor how effective the process was and whether any themes identified had been addressed. The practice manager analysed this information and identified learning and shared with staff improvements needed. When needed the practice manager provided support for staff.

A complaints leaflet was available from the reception desk and contained information on referring the complaint to the Parliamentary Ombudsman, if the complainant was not satisfied with the response from the practice.

Are services well-led?

Good

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

Our findings

Vision and Strategy

Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care. The practice had a clear vision and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to patients. These were communicated to patients in the surgery newsletter and on the practice website.

Staff told us the practice had an open and democratic way of working to ensure that everybody felt part of the team. In our discussions with nurses and non-clinical staff effective communication was shown as a strength for the practice, and that there was a caring ethos of putting patients first that resulted from the GP leadership.

Governance Arrangements

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

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

The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, A patient had been prescribed an uncommon medicine that needed regular monitoring. It was found that this was not happening and an action plan was set to improve knowledge of share cared guidance for uncommon medicines and as a result the practice improved its system for monitoring of disease-modifying antirheumatic medicines and ensuring blood tests were completed.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

Practice seeks and acts on feedback from users, public and staff.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. All complaints were discussed and minutes taken at meetings with the clinical staff, evidence of this was seen in the minutes from the meetings.

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a patient participation group and the practice worked with them to help improve the care services. Patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Are services well-led?

Good

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

The practice joined the Wessex GP Educational Trust in 2012. Part of the membership requirement was to hold regular in-house education meetings. The Wessex GP Educational Trust (WGPET) was formed in 1990 to provide funding for educational events run by GP Tutors. It continues to fund a wide range of events from one hour lectures to week-long refresher courses throughout the Wessex Deanery.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example a patient had slipped on a wet floor by the reception door. The patient told the practice they had not wiped their feet properly and did not want to make anything more of the incident. The patient left with leaving any details. The practice decided to investigate the incident and was able to identify the patient from the appointments. The area of floor was immediately assessed and it was found that it was not very wet. The practice instigated a procedure when there was bad weather and the floor may be wet to place out “A” board notices advising patients of wet floors.