Esplanade Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Esplanade Surgery on 11 March 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a 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.

There were areas where the provider could make improvements and should:

Consider monitoring any actions taken as a result of a complaint to show that learning has been put into place and is effective.

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 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 received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a 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. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

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 patient participation group 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 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, patients deemed at risk were on proactive care programmes. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice worked with a Care Navigator who was a trained professional able to access social support and provide advice on areas such as support networks and benefit entitlement.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medicine 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. 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. The practice offered a full range of childhood immunisations in line with national guidance. 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 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

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Extended hours surgeries were offered every alternate Monday and Wednesday and on two Saturday mornings a month.

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 homeless people, travellers and those with a learning disability and offered longer appointments for people within this population group.

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

The practice had signposted patients experiencing poor mental health to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Some comment cards singled out particular members of staff for praise and a common theme was that patients were treated as individuals at all times. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Results from the practice's patient participation group surveys showed that patients were satisfied with the care and treatment they received.

- Results from the National GP patient survey showed that 91% of patients described their overall experience of their GP practice as fairly good or good, compared with the national average of 85.75%.

Other areas where the practice was similar to or above the national average included:

- 93% said the GP was good at listening to them compared to the national average of 88%.
- 84% said the GP gave them enough time compared to national average of 86%.
- 99% said they had confidence and trust in the last GP they saw compared to the national average of 93%

Areas for improvement

Action the service SHOULD take to improve

Consider monitoring any actions taken as a result of a complaint to show that learning has been put into place and is effective.

Esplanade Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

A CQC Lead Inspector. The team included a GP and practice manager specialist advisor.

Background to Esplanade Surgery

The Esplanade Surgery is situated at 19 The Esplanade, Ryde, Isle of Wight, PO33 2EH. The practice has seven GP partners. Four of the partners are male and three of the partners are female. The practice has approximately 10,000 patients registered with it, although this increases during the holiday season.

The GP partners are supported by a practice manager, six practice nurses and two healthcare assistants. In addition there is a team of reception and administration staff. The practice is a teaching practice and facilitates training for year five medical students.

The practice has a higher number of male patients in the 45 to 49 year age group and 65-69 year age group when compared with the England average. There is also a higher proportion of female aged 65-69 years in the practice population.

The practice is open between 8.30am and 6.30pm Monday to Friday. Appointments are from 8.30am to 12.40pm every morning and 2pm to 6pm in the afternoons. Extended hours surgeries are offered every alternate Monday and Wednesday and on two Saturday mornings each month.

The provider has opted out of providing out of hours services, which are provided by the out of hours GPs at St Mary's Hospital via the 111 service.

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 that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 11 March 2015 at The Esplanade Surgery. During our visit we spoke with a range of staff which included GPs, nurses, the practice manager and reception staff. We spoke with patients who used the service. We reviewed 16 comment cards where patients and members of the public shared their views and experiences of the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our

Detailed findings

areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website.

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people 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 comments and complaints received from patients. Staff were aware of their responsibilities to raise concerns and knew how to report incidents and near misses. For example, we were told about a recent medicine alert related to the long term use of Domperidone, an anti-sickness medication. The GPs in the practice reviewed all patients on this medicine to ensure it was still necessary.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently and so could show evidence of a safe track record over time.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed a sample of significant events that had occurred in the past 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda every fortnight. National patient safety alerts were received via email and the practice manager was responsible for cascading information. The nominated prescribing lead GP was responsible for undertaking medicine searches on the practice's computer system when a medicine alert was received.

Nurses and health care assistants who worked at the practice met as a team daily and had formal minuted weekly meetings where significant events and incidents were discussed and learning implemented if needed. Examples were given of significant events which included an event where a patient's medicine had been changed by the local hospital, but another medicine which was no longer needed was still being taken by the patient. The GP responsible for this patient's care completed a significant event form. Learning identified included ensuring that prescriptions for medicines were rewritten following a hospital admission on receipt of the discharge summary.

Another example related to a patient who needed a reducing dose of medicine once they had been discharged from hospital. This was not clearly stated on the discharge summary and the patient had a period where they were not reducing the medicine as needed. The practice was alerted by a pharmacist that the dose was not being reduced. As a result the practice reviewed their systems and learning points included better communication with the hospital; a code for change of medicines on patient records; and an alert to show that the medicine was a reducing dose.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Training records showed that all GPs had received or were booked to receive training at level three for safeguarding children. The practice had a lead GP for safeguarding children and a lead GP for safeguarding adults. We spoke with both of these GPs and found they had received additional training to enable them to carry out their role. Both GPs said they were responsible for ensuring all staff were kept up to date with safeguarding.

We spoke with nurses, healthcare assistants and administration staff, all of whom confirmed they had received safeguarding training relevant to their role. Staff were able to identify the lead GPs for safeguarding. They were able to recognise signs of abuse in older people, vulnerable adults and children. Staff were also aware of their responsibilities to share information, properly record safeguarding concerns and how to contact relevant agencies in and out of normal hours. An example of a safeguarding concern related to a young child that had been injured, we found appropriate action had been taken.

The practice met every two months with health visitors to discuss vulnerable children and had a system in place to highlight if a child was a frequent attender to A & E. One GP said that if a child did not attended for an appointment, for example, for an immunisation then the practice would contact the person with parental responsibility to check on the child's welfare and rearrange the appointment.

Another example given related to a vulnerable patient. The practice raised a safeguarding alert and supported the patient. The GP adult safeguarding lead was able to explain Deprivation of Liberty Safeguards and use of restraint and when these should be considered. They also mentioned

the appropriate actions to ensure patients were not unduly distressed, such as not sectioning a patient with an enduring mental health condition in the middle of the night if this could be avoided.

There was a chaperone policy which was visible in the waiting room and consulting rooms. (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). All nursing staff, including health care assistants, had been trained to be a chaperone. They had all received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Medicines management

We checked medicines stored in treatment rooms and medicine refrigerators and found they were stored securely and 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. GPs carried some medicines in their GP bags and these were also checked and this was recorded. Expired and unwanted medicines were disposed of in line with waste regulations.

Medicine refrigerator temperatures were monitored twice a day when the practice was open. Records we looked at confirmed that medicines which required refrigeration were stored at the appropriate temperature. Staff told us there had been an incident in October 2014 when the power supply to one medicine refrigerator had been switched off. The practice contacted the medicine manufacturer for advice and guidance on whether to use the medicines or safely dispose of them.

The nurses used Patient Group Directions to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw examples of these directives and found they were in date and current.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescriptions for use in printers and those for hand written prescriptions were handled in accordance with national guidance and were tracked through the practice and kept securely at all times.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying medicines, which included regular monitoring. Appropriate action was taken based on the results. The practice had a significant event where a patient who was on methotrexate had not had a consultant review for three years. The practice had altered its systems to ensure that patients on disease modifying medicines were reviewed at least annually by a specialist consultant.

Cleanliness and infection control

We saw that the premises were visibly clean and tidy. Routine cleaning was carried out by contractors and there were systems in place to check on standards of cleanliness. The practice had a message book in which they could note areas which needed to be addressed and the cleaning company would indicate when the work had been completed. There were comprehensive cleaning schedules in place which detailed how often each area of the practice should be cleaned. Patients said they had no concerns about cleanliness or infection control.

The practice had arrangements in place to manage clinical waste, non-hazardous waste and used needles and medicines which were in line with national guidance and regulations. We saw clinical rooms had colour coded waste bags and sharps containers to ensure waste was appropriately segregated prior to disposal.

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 and aprons 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. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We looked at the policy and found it complied with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. The policy was due to be reviewed in July 2016. We found there was information on the consultant microbiologist and health protection agency if further advice was needed. The policy also set out that all staff should receive infection control training annually. This had been provided by the local clinical commissioning group (CCG). Staff we spoke with confirmed this. We also saw records which evidenced

that hand washing technique checks had been carried out on all staff in the previous 12 months. Staff also signed to confirmed they had received and read guidance on the correct hand washing technique to use.

The practice had nominated infection control leads who linked with the infection control lead for the CCG for advice and support. A full audit of infection control processes within the practice had been carried out and one of the leads was collating the information to produce an action plan and annual statement.

Notices about hand hygiene techniques were displayed above sinks in consulting rooms, treatment rooms and toilets. Supplies of liquid hand soap, hand cleansing gel and paper towels were provided. The reception desk had a supply of hand cleansing gel for patients to use when they entered the building.

The practice had designated clinical rooms for changing dressings and carrying out minor surgical procedures. We saw these two rooms had sealed flooring which was easily cleaned and disposable equipment was used during procedures. Where disposable privacy curtains were used these were changed at least every six months, or sooner if needed. Where the curtains were made of cloth these were changed and washed every three months or sooner if needed.

Equipment

Staff said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We looked at records for equipment testing and calibration. (Calibration is where pieces of equipment such as weighing scales and thermometers are tested to ensure they provide accurate measurements). We found that all equipment was tested and maintained. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in 2014. Fire alarms were checked on a monthly basis and recorded.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it followed when recruiting clinical and non-clinical staff and what checks were needed. The practice manager told us that when a position became vacant they would discuss with the partners skill mix, hours available, training needs and whether an existing member of staff could fill the role. We looked at four staff records, two of whom had been recruited since April 2013 when the practice was first registered with the CQC. We found that files contained the required information stated in the regulations. For example, there was evidence of the member of staff's full employment history and evidence of satisfactory conduct in previous employment. Interview notes were available, which was in line with best practice.

When needed checks with professionals bodies such as the Nursing and Midwifery Council were made to ensure that nurses were registered to practice. The GP performers list was also checked when a new GP was recruited.

Staff said that they covered for each other's annual leave and they had received training so they could multi task and perform more than one role. For example, reception duties or prescribing clerk. We found there were sufficient numbers of staff available to maintain the smooth running of the practice. And there were always enough staff on duty to keep patients safe. When needed locum GPs were used to cover long term absence or sickness. A locum GP is a GP who temporarily fulfils the duties of a permanent GP.

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. Health and safety risk assessments had been carried out in each room on a regular basis and staff said visual checks were made daily. Fire extinguishers had been serviced and tested in June 2014 and the fire alarm was also serviced in June 2014. Fire doors were fitted with self-closing devices that would operate in the event of a fire.

Arrangements to deal with emergencies and major incidents

Emergency equipment was available including access to 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.). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly. Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the

Good

Are services safe?

medicines we checked were in date and fit for use. Staff training records showed that relevant staff had received training in managing Anaphylaxis, a severe allergic reaction.

The practice's business contingency plan was being reviewed by the practice manager at the time of our visit. We saw that the plan included information about arrangements to use another GP's premises if the practice was out of action. There was also information on procedures to be followed in the event of a power failure or loss of computer systems. We found that information on the computer systems was backed up daily on tape and stored securely in a fire proof safe. The practice manager said that once their review of the plan was completed it would be shared with the team leaders for staff groups. Such as nurses and administration staff, and copies would be kept securely in their homes.

The practice manager said that if in house cover was required then urgent tasks would be carried out based on risk. Appointment capacity was reviewed daily and if needed GPs were asked to free up appointment times to manage demand.

There were personal alarms systems on computers and desks to keep staff safe and allow them to summon help if needed. For example, if a patient or visitor was behaving in a threatening manner.

We noted that there was an external fire escape made of wood, which was no longer used. The practice manager said that this would be removed; we noted that access to this fire escape was not possible and alternative escape routes had been identified in the event of the need to evacuate the building. The practice had held a fire drill in 2014, but had not noted which staff members were present in the building and the time taken to evacuate the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff were able to clearly outline the rationale for their approaches to assessment and treatment. They were familiar with current best practice guidance, and accessed information from the National Institute for Health and Care excellence and from local commissioners. GPs said that they used templates which were embedded on their computer systems to assess and treat patients. These templates were in line with national guidance and locally adapted to fit the needs of the patients that were registered with the practice. Examples given included safe prescribing of antibiotics and chronic disease management, such as asthma.

The practice had identified those patients who were deemed to be at high risk of inappropriate hospital admission. These patients had care plans in place which were reviewed regularly with the patient. The care plans set out how to meet their needs to assist in reducing the need for them to go into hospital. If one of these patients was admitted to hospital their GP would review the admission to ensure it was medically appropriate. When needed amendments to care plans were made to ensure that all their needs were continuing to be met.

The GPs told us that they lead in specialist clinical areas such as diabetes, sexual health, women's health and heart disease. The practice nurses supported this work and ran nurse led clinics for long term conditions such as respiratory (breathing) conditions.

Management, monitoring and improving outcomes for people

Information about patients care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and medicines management. This information was used to support the practice to carry out clinical audits.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from 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 and for the implementation of preventative measures).

The practice had a system in place for completing clinical audit cycles. We saw a sample of clinical audits that had been completed. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. Another clinical audit related to use of the combined contraceptive pill and whether risk factors were being identified. In particular the risk of developing a deep vein thrombosis. The results are shown below:

Adherence % (2013)

BMI recorded in last year
74%

BP recorded in last year
97%

History or FH of VTE recorded
70%

History of migraine recorded
88%

Smoking status recorded
99%

Adherence % (2015)

BMI recorded in last year
72%

BP recorded in last year
98%

History or FH of VTE recorded
82%

History of migraine recorded
95%

Smoking status recorded
98%

BMI is a patients' body mass index and indicates whether they are clinically obese or not. History or family history of VTE means whether the patient or near relatives such as their parents have experienced a deep vein thrombosis. Further action points had been identified to continue to improve the recording of information.

Good

Are services effective?

(for example, treatment is effective)

Other examples included an audit on the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 99% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- The percentage of patients living with dementia who had had a face to face review in the preceding 12 months was comparable to the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures. For example, the percentage of non-steroidal anti-inflammatory medicines was 80.67% compared to 71.25% national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Effective staffing

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. Nurses said that they considered they were supported clinically and had appropriate training to carry out their role. For example, on administration of vaccines. Those with extended roles such as seeing patients with asthma and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Safeguarding and basic life support were included as part of the practice's mandatory training programme. Records we saw showed staff had received training on these mandatory topics. The practice's appraisal system specified that all staff would have an annual appraisal. However, we were told that these had not occurred for the past two years for nursing staff, due to absence. We saw evidence which showed that nurses would receive an appraisal prior to the end of March 2015. Training was provided either online or in formal sessions.

All new staff undertook a comprehensive induction programme which involved shadowing all members of staff who worked in the practice, so they could gain an understanding of how the practice ran as a whole. The induction also included used of the computer systems, health and safety and fire safety.

All GPs were up to date with their yearly continuing professional development requirements and all either have 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).

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to

Good

Are services effective?

(for example, treatment is effective)

fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

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 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from hospital outpatient departments were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up. Emergency hospital admission rates for the practice were similar to national averages at 13.5 per 1000 of the population).

The practice held multidisciplinary team meetings at least every two months to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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 to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery had being followed.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice's performance for the cervical screening programme was 86.44%, which above the national average of 81.89%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 73.52%, and at risk groups 52.29%. These were similar and above national averages respectively.

Information on health promotion was available at the practice in the form of leaflets and on its website. This included information on support groups available and immunisations available at the practice. The practice offered a full range of childhood vaccinations in line with national guidance.

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 included information from the national patient survey 2013-14 and a survey of 566 patients undertaken by the practice's patient participation group (PPG). (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also above average or similar to for its satisfaction scores on consultations with doctors and nurses. For example:

- 93% said the GP was good at listening to them compared to the national average of 88%.
- 84% said the GP gave them enough time compared to national average of 86%.
- 99% said they had confidence and trust in the last GP they saw compared to the national average of 93%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 16 completed cards and these were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Some comment cards singled out particular members of staff for praise and a common theme was that patients were treated as individuals at all times. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice were aware that the due to the small space in the reception area it was sometimes possible to overhear conversations. They had implemented a queuing system to minimise the risk of confidential conversations being over heard. The practice were also looking at providing a glass partition to assist in minimising any potential breaches of confidentiality. Additionally, 92% said they found the receptionists at the practice helpful compared to the national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. The practice experienced a higher number of temporary patients during the summer months when tourist numbers were high. They would accommodate temporary patients as needed and liaised with the patients permanent GPs about any treatment or care they had provided. The practice said that there were a proportion of patients who were homeless these patients were offered the same care and treatment as patients who had permanent residences.

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:

- 92% said the last GP they saw was good at explaining tests and treatments compared to the national average of 82%.
- 88% said the last GP they saw was good at involving them in decisions about their care compared to the national average of 75%.

Good

Are services caring?

Patients we spoke with on the day of our inspection told us that health issues were discussed with them by GPs and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 93% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 83%.
- 94% said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 79%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood. For example, the practice worked with a Care Navigator a trained professional who was able to access social care in patients' homes in order that they would receive appropriate community support to minimise the need for hospital admission. The Care Navigator was also able to provide information and advice on benefits available and linked with Age UK to provide suitable care for older patients. The healthcare assistants employed by the practice had been trained to carry out health checks, monitor patients' blood clotting rate when they were on blood thinning medicines, and undertook home visits to provide support to patients who had been discharged from hospital.

The practice engaged with the clinical commissioning group (CCG) regularly and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example. Use of the Care Navigator which had been rolled out island wide.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group. For example, continuing to monitor access to appointments to ensure it met the needs of patients and support collaborative working with other GP practices to provide services such as home visits and emergency appointments for their respective patients from one location on a rotational basis.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. In addition one of the GPs spoke Polish. The practice was aware of patients who misused drugs and would see these patients when they presented at the practice. The practice also ensured that a consistent approach to supporting patients who were misusing drugs was maintained.

The premises and services had been adapted to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties and there were consulting rooms and treatment rooms on the ground floor. There were access enabled toilets and baby changing facilities. The waiting area was compact, but space had been made for wheelchairs and prams.

Staff told us that they had patients who were of "no fixed abode" and would see someone if they came to the practice asking to be seen and would register the patient so they could access services.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The surgery was open from 8am to 6.30pm Monday to Friday. Appointments were available from 8.30am to 12.40 pm and 2pm to 6pm on weekdays. A duty GP was available each day until 6.30pm. In addition pre-bookable extended hours appointments were available between 6.30pm to 8.45pm on alternate Monday and Wednesday evenings and on two Saturdays a month between 8.00am to 11.30am. A young person's drop in clinic was held every Wednesday afternoon for patients aged 13 to 25 years old, to provide support on general health matters and sexual health. These patients did not have to be registered with the practice to attend. These clinics were nurse led and funded by Public Health England. The practice offered same day appointments. Patients we spoke with confirmed this; one added that when there were no same day appointments available, reception staff would contact them by telephone if one became available later in the day.

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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. The practice also provided a service for local care homes in the area and undertook weekly visits when needed.

The practice had a staggered system for home visits, which commenced at 8.30am in the morning and continued throughout the day. This enabled the practice to liaise with other health professionals about providing suitable care and treatment for patients. Each GPs day was organised into sections so that for part of the day they dealt with routine appointments and administration. The remainder of the day was set aside for home visits and duty GP tasks. These sections were moved around so that all GPs covered mornings, afternoons and extended hours surgeries.

Reception staff said that they were also able to request extra appointment slots to cope with demand.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 92% were satisfied with the practice's opening hours compared to the national average of 79%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking up to six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its 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. Patients were able to raise concerns in person, in writing, by telephone, or a note handed in at reception. The practice manager was responsible for dealing with complaints. Information on how to complain was displayed in the waiting room and in the practice booklet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

The practice had received two complaints in the past 12 months. We saw evidence which confirmed these were dealt with in a timely way and resolved as far as practically possible to the patient's satisfaction. We noted that complaints were discussed in practice meetings, but it was unclear on how learning from complaints and any actions required were monitored.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The strategy and business plan were not formally written down but the practice told us about them. The practice vision and values included providing a full service to embrace all changes in health care provision and recognised the need to work with other practices to achieve this aim. The practice considered that their strengths included cohesive team working with shared responsibility and having a supportive flexible approach to provide the best possible care for their patients. This was demonstrated throughout the inspection and confirmed when we spoke with patients and reviewed comment cards

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies which included: sickness; disciplinary; return to work and equality. We saw that these policies were used in the day to day running of the practice. We found evidence of the return to work policy being implemented when a member of staff returned from long term sick leave. The majority the policies and procedures we looked at had been reviewed annually and were up to date. However, the whistleblowing policy did not have the up to date details of a named contact or contact details for the Care Quality Commission. The policies were contained in the staff handbook which had been reviewed in 2014.

There was a clear leadership structure with 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 12 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were mostly effective. The included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example prescribing of non-steroidal anti-inflammatory medicines. Evidence from other data sources, including incidents was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented. The practice monitored risks to identify any areas that needed addressing.

The practice held monthly meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed. Other areas discussed included recruitment, funding and clinical care.

Leadership, openness and transparency

The GP partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. GP partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise

Are services well-led?

Good

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

any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the GP partners in the practice.

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

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. The PPG had carried out annual surveys and met every three to six months. We were shown the analysis of the last patient survey undertaken in 2014. The results and actions agreed from these surveys were available on the practice website. We spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The PPG had worked with the practice to undertake a one off survey about what music should be played in the waiting area. The PPG had also supported the change in the telephone system at the practice and coordinated information between the practice and its patients on options available prior to a new system being installed. The practice manager produced a quarterly newsletter which was made available on the practice website and gave information on the Friends and Family Test, refurbishment of the practice and ways to stay healthy.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. Staff said that there was a comments book in their staff room to record ideas and issues. This book was read by team leaders and shared with the partners. An example given was for patients to have annual health reviews at a specified time in the year to allow for relevant patient recall, if any concerns were identified at the check. Staff added that they always received feedback from the GP partners on any ideas or concerns they had highlighted in the comment book.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. However, we found that not all staff had received an appraisal in the past two years. We were shown a plan which identified all staff that needed appraisals and these had been planned for and would be completed by the end of March 2015. Staff told us that the practice was very supportive of training and that they had protected training afternoons three times a year where guest speakers and trainers attended.

The practice was a GP training practice and had supported medical students who were in the fifth year of their training for a period of two weeks. One of the GPs presented seminars for medical students at Southampton University and seminars or formal teaching sessions to other GPs.

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.

The practice also met with other GP practices as part of the Isle of Wight's North and East Locality Group, to benchmark practice and discuss areas where they could work collaboratively, such as harmonising phlebotomy services or policy decisions, for example access to IVF. This group involved representatives from the clinical commissioning group.