Emsworth Surgery

Quality Report

6 North Street
Emsworth
Hampshire
PO10 7DD
Tel: 01243 378812
Website: www.emsworthsurgery.co.uk

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

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 Emsworth Surgery on 23 July 2015. Overall the practice is rated as good.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. Opportunity for learning from internal and external incidents and complaints was maximised.
- The practice had systems in place to improve outcomes for patients. The practice had updated the practice computer system with the Ardens tools, which is a clinical safety tool that assists in safer prescribing of medicines, recalling patients for routine checks and included templates to assist in the recording and management of patients' treatment to improve outcomes.
- The practice had comprehensive systems in place to provide health promotion advice to patients, which included a quarterly newsletter and health education events at a local venue. The practice also referred patients to a lunch club that was organised by the patient participation group in order to reduce medical conditions associated with social isolation.
- Patients indicated that they were happy with the care and treatment that they received at the practice and the national GP survey indicated that the practice score was in line with Clinical Commissioning Group averages and above national averages for the care provided by GPs and nurses.
- Data for 2013 to 2014 indicated that the practice had achieved 93.85% of the total quality indicator points available compared to the national average of 94.2%

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

The provider should:

- Routinely record reviews and actions taken as a result of significant events and complaints.
- Ensure that the Health and Safety Policy has a date that it was written and a date for review. Also undertake and document health and safety audits.

Summary of findings

- Ensure that there is a programme for infection control audits to be completed every six months.
- Ensure the disposal of all consumable stores that have passed their expiry date.
- Update the practice information leaflet to ensure it includes correct information such as current opening times.

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 report incidents and near misses. The practice used opportunities to learn from incidents to support improvements to the service provided. However we found that minuted meetings to discuss significant events were only documented annually. The practice operated from an old building with limited space. Consumable stores had to be stored in an external building and this made stock control difficult. We found old consumable stores that were not in use but these had not been disposed of. The practice had systems in place to manage risks to patients and had been proactive in responding to an infection control audit completed by the clinical commissioning group which had identified areas were improvements could be made but the practice had not instigated it's own programme of infection control audits.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that the outcomes for patients were either in line or above national averages. The practice provided care and treatment in line with the National Institute for Health and Care Excellence. Patients' needs were assessed and the practice had systems in place to monitor patient outcomes and to recall patients for health checks and screening. The practice provided health advice and support to patients using the practice newsletter and providing health promotion events organised in association with the patient participation group. Staff received appropriate training to carry out their roles and received appraisals. Staff worked with multi-disciplinary teams including safeguarding teams, district nurses, health visitors and MacMillan nurses. However we found that information on the practice leaflet was not current and conflicted information that was provided elsewhere.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients indicated that they were treated with dignity and respect and that they were involved in decisions about their care. Patients' confidentiality was maintained. The practice took additional steps to protect patient confidentiality as many of the patients were known to staff. Information about the services was available to patients on the practice website and in the practice booklet.

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 population and engaged with the local clinical commissioning group to secure improvements to services where these were identified. Patients had a named GP. GPs and nurses visited care homes to provide routine treatment and health checks to patients who could not access the service easily. The practice responded proactively to information provided by patients and staff and used this information to make improvements to the service provided. GPs and local organisations jointly provided educational talks on the management of conditions such as diabetes as part of the health promotion and prevention process.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a patient's charter that was available in the practice information leaflet. There was a clear leadership structure and staff were clear about their roles and responsibilities. Staff had been nominated to undertake lead roles in areas such as safeguarding and infection control and had been given training to support these roles. Policies and procedures were in place and regular staff meetings were held. However some policies such as the Health and Safety Policy did not have the date that it had been reviewed recorded. The practice had systems in place to monitor risks to staff and patients and actively sought feedback from staff and patients, which it acted on.

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. A total of 30% of the patient population were over the age of 65. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. All care homes were allocated a named GP who provided care to residents who lived in care homes and carried out visits. Nurses visited care homes to provided immunisations against flu, shingles and pneumonia infections. The practice provided support to patients receiving end of life care in line with the Gold Standards Framework. The patients participation group held a monthly luncheon club for older patients in order to reduce social isolation.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. GPs and nursing staff had lead roles in chronic disease management. Patients at risk of hospital admission were identified as a priority and the number of emergency admissions for both patients with cancer and patients with Ambulatory Care Sensitive Conditions was lower than the national average. All patients were allocated a named GP and patients with long term conditions were offered longer appointments and home visits were available when needed. Patients with long-term conditions were recalled for structured care reviews. The Patient Participation Group ran educational events, where GPs and nurses provided presentations to improve understanding of conditions such as diabetes and Chronic Obstructive Pulmonary Disease (COPD).

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Immunisation rates for pre-school children were in line with national averages. The practice followed up children who did not attend for appointments by telephone, letter or home visits. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were vulnerable. Multi-disciplinary safeguarding meetings were held with health visitors every three months. The practice used best practice systems to improve prescribing in children. Appointments were available outside of school hours and the duty GP was available to assess children every day.

Summary of findings

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 practice adjusted the services if offered to ensure that these were accessible, flexible and offered continuity of care. Appointments were available until 7.30 pm on Monday to Thursdays and from 7.30am on Wednesday, Thursdays and Fridays. The practice offered online services, for example, on-line appointment bookings and prescriptions. The practice provided a full range of health screening that reflected the needs of this age group such as health checks for people over the age of 40.

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 had a register of patients who were vulnerable, including those with a learning disability and those who were carers. The practice provided annual reviews for patients with learning disabilities. The practice provided care to two care homes for patients with learning disabilities and nurse visited these care homes to provide flu immunisations to residents. The practice had a named lead who provided support to carers. The practice provided care and treatment to people that were homeless and people that were residing in temporary accommodation provided by the church.

The practice worked in multi-disciplinary teams to provide care and support to vulnerable patients and staff had completed training in safeguarding children and vulnerable adults. Staff were aware of how to recognise the types and signs of abuse and how to contact the 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 used tools to identify patients with conditions such as dementia, depression and anxiety disorders. The number of patients diagnosed with dementia had increased since the tools had been used to support diagnosis. Outcomes for patients experiencing poor mental health were good. A total of 94.92% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months compared to the national average of 86.04%. The practice supported patients to access cognitive behaviour therapy services and had systems in place to reduce the number of antipsychotic medications prescribed to patients with dementia.

Summary of findings

What people who use the service say

The national GP patient survey results published on 8 January 2015 showed the practice to be performing above local and national averages. There were 122 responses and a response rate of 48%, and represents 0.95% of the patient population.

- 90.5% of respondents found it easy to get through to the surgery by telephone compared to the clinical commissioning group (CCG) average of 84.3% and the national average of 74.4%.
- 91.8% of respondents found the receptionists at this practice helpful compared with the CCG average of 89.7% and the national average of 86.9%.
- 84.4% of respondents with a preferred GP usually got to see or speak to that GP compared with the CCG average of 71.6% and the national average of 60.5%.
- 92% of respondents were able to get an appointment or speak to someone last time they tried compared to the CCG average of 89.2% and the national average of 85.4%.
- 100% of respondents said that the last appointment they got was convenient compared to the CCG average of 94.1% and the national average of 85.4%.
- 88.8% of respondents described their experience of making an appointment as good compared to the CCG average of 79.8% and the national average of 73.8%.
- 79% of respondents indicated that they usually wait 15 minutes or less after their appointment time to be seen compared with the CCG average of 61.5% and the national average of 65.2%.
- 73.7% of respondents indicated that they do not normally have to wait too long to be seen compared with the CCG average of 57.6% and the national average of 57.8%.
- The practice provided a minor injuries walk in service from 8am to 6.30pm Monday to Friday, which was open to registered and non-registered patients.

As part of our inspection we also asked for CQC comments cards to be completed by patients prior to our inspection. We received 19 comments cards from patients. The majority of patients commented on the high quality of care provided at the surgery but three patients indicated that whilst the care was good, the premises needed to be expanded to meet the need of an increased patient population and one patient commented that it was difficult to get an appointment, especially with a named GP.

We reviewed data from the Family and Friends Test for June 2015. There were 81 respondents to the test and 76 respondents indicated that they would be highly likely or likely to recommend the practice to their friends and family.

Areas for improvement

Action the service SHOULD take to improve

- Routinely record reviews and actions taken as a result of significant events and complaints.
- Ensure that the Health and Safety Policy has a date that it was written and a date for review. Also undertake and document health and safety audits.
- Ensure that there is a programme for infection control audits to be completed every six months.
- Ensure the disposal of all consumable stores that have passed their expiry date.
- Update the practice information leaflet to ensure it includes correct information such as current opening times.

Emsworth Surgery

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 practice manager specialist advisor.

Background to Emsworth Surgery

Emsworth Surgery is located at 6 North Street, Emsworth, Hampshire, PO10 7DD. The practice is the only GP practice in the town and provides care to 12,886 patients.

Staff included eight GP partners and a GP registrar, which equates to 6.5 whole time GP equivalents. Four GPs are female and four GPs are male. There are also four practice nurses, a healthcare assistant, a phlebotomist, a practice manager, reception and administration staff. The practice is a teaching practice and also trains student doctors in conjunction with Southampton University. The practice has a Personal Medical Services contract (a locally agreed alternative to the standard GMS contract used when services are agreed locally with a practice which may include additional services beyond the standard contract).

Approximately 30% of the patient population are over the age of 65 and the practice provides care to residents in care homes.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8am to 11am and 3pm to 6pm on weekdays. Extended hours surgeries are offered until 7.30pm on Mondays, Tuesdays, Wednesdays and Thursdays and from 7.30am on Wednesday, Thursday and Fridays. The practice provides a minor injuries walk in service from 8am to 6.30pm Monday to Friday, which is open to registered and non-registered patients.

The practice has one branch surgery, The George and Dragon Surgery, The Square, Westbourne, Emsworth, PO10 8UE which was not visited as part of our inspection.

The practice has opted out of providing out-of-hours services to their own patients. Patients can obtain out of hours care using the 111 service and care is provided by Hampshire Doctors On Call.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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. We carried out an announced visit on 23 July 2015. During our visit we spoke with a range of staff, including GPs, nurses, the practice manager, administration and reception staff and spoke with patients who used the service. We observed how people were being cared for and reviewed documentation such as policies and procedures. 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:

Detailed findings

- 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 and learning

There was an open and transparent approach and a system in place for reporting significant events. A significant event reporting form was available to all staff on the practice computer system and staff told us they would complete the form and send it to a named GP, who was lead for significant events management. Patients who were affected by significant events were contacted by their named GP. We reviewed 15 significant events, which had occurred in the last 12 months. Each event record listed discussions held about the event and a record of planned changes that had been actioned to reduce the likelihood of the event recurring. For example, we reviewed an incident were a patient had been prescribed an incorrect quantity of medication after the computer system had calculated the quantity required. This was identified by the pharmacist. In response to this event, staff had completed a training session to ensure that they prescribed through a newly installed computer programme. The system had been designed to reduce prescribing errors. Information and learning from significant events was shared with the Clinical Commission Group (CCG). Complaints were automatically managed in the same way as significant events. The practice held a significant events meeting annually to review all significant events and complaints that had occurred in the last 12 months. Whilst significant events were discussed throughout the year at weekly GP meetings, these meetings were not minuted. Staff told us that learning was implemented as a result of events such as a training session on the new prescribing but the timescales for this were not documented and there was no record that this learning had taken place.

Safety was monitored using information from a range of sources, including information from the National Institute for Health and Care Excellence (NICE) Guidance. GPs were supported by an additional clinical safety tool that had been installed onto the practice system and helped GPs to identify additional options for treatment that were available and adhere to NICE guidance.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep people safe, which included:

- A GP was the nominated safety lead for the practice and attended safety seminars that were held by the CCG.
- Arrangements were in place to safeguard adults and children from abuse. Relevant legislation, local requirements and policies were accessible to all staff using the practice computer system. A GP was the named lead in safeguarding and another GP was the named deputy lead to cover periods of absence. Staff told us that they would speak to the named lead if they had concerns about a patient's welfare. GPs attended meetings with the local safeguarding team every three months and also held meetings with school nurses if they had concerns about a child who may be vulnerable. GPs had received training in safeguarding children to Level three and training in safeguarding vulnerable adults. Other staff had received training in safeguarding that was appropriate to their role.
- A notice was displayed in the waiting room, advising patients that chaperones were available, if required. Nurses and Healthcare Assistants who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). 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.
- There were procedures in place for monitoring and managing risks to patients and staff. There was a Health and Safety Policy available, that contained current information but the policy did not have a date on it and did not identify a date for review. Health and Safety information was available to staff, including the procedure for activating panic buttons in an emergency situation. However there were no documented health and safety audits that had been undertaken at the practice. The cleaning cupboard did not lock, which meant that some chemicals were accessible to patients and we were advised that a lock had been fitted immediately after our inspection. The practice had a fire risk assessment and appropriate fire signage. Fire safety equipment was tested in March 2015 and a fire drill evacuation test had been completed in June 2015.
- The practice responded to information of concern that may impact upon patient safety. The practice had called in the clinical safety team to manage concerns after data migration to a new computer system had compromised patient care. We were given a full report regarding the management of this incident. We saw that

action had been taken in response to an alert had been raised by the Medical and Health Regulatory Agency and that patients glucose testing machines had been replaced because the alert indicated that they were not safe to use.

- Electrical equipment was checked to ensure that the equipment was safe to use and clinical equipment was checked to ensure that it was working properly. Portable appliance testing had been completed on electrical equipment in November 2014 and other equipment checks had been completed in July 2015. The practice had other risk assessments in place to monitor safety of the premises and a risk assessment for the management of legionella had been updated in June 2015. Legionella is a term for particular bacteria which can contaminate water systems in buildings and cause disease.
- Appropriate standards of cleanliness and hygiene were followed and we observed the premises to be clean and tidy. The practice nurse was the infection control lead and liaised with the infection control lead from the CCG to ensure that procedures were updated. The lead had received additional training in infection control and provided internal training to other members of staff. Internal audits to monitor infection control procedures had not been completed but the CCG lead had completed an external audit on the practice. The report had been received on 3 July 2015 and the practice had taken action in response to the findings of the report. The infection control lead identified that she would complete an internal audit to review these findings and was aware that this should be completed within six months. The practice was located in an older building and to meet best practice standards staff had stopped using one treatment room for clinical procedures and refurbished another room in response to the audit findings.
- The arrangements for managing medicines, including emergency drugs and vaccinations, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). The practice had a named GP who was lead for prescribing medicines. GPs had attended a prescribing meeting on 19 April 2015 and two monthly prescribing meetings with the clinical commissioning group. The practice used a clinical safety tool that had been added to the practice computer system to support safe prescribing. The practice was not an outlier for any of the prescribing indicators that were identified by the CCG but were proactive in working with community pharmacists to improve and completed audits to identify where improvements in prescribing could be achieved. A repeat prescriptions clerk, who was previously a pharmacy technician was employed by the practice and they took the lead on managing repeat prescriptions. We saw that they raised concerns with the GPs if patients prescriptions were not routine or if a review was required. Prescription pads were stored securely and there were systems in place to monitor their use.
- The practice did not have systems in place to manage the rotation of the stock of consumable items such as masks but these items were not in use. Due to the constraints of the building the practice used an external store to hold consumable items. The store was cramped and made stock rotation difficult. This meant that some older stock at the back of the store was out of date and in need of disposal. We were also told that the fitting of contraceptive devices was not being carried out in the practice at present and the devices had past their expiry date and were in need of disposal.
- The practice had a comprehensive recruitment policy in place. We reviewed staff files and found that appropriate recruitment checks had been undertaken on staff prior to employment. For example, proof of identification, checks on satisfactory conduct in previous employment in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. The practice used an occupational health assessment in order to identify whether any measures were required to support staff with health conditions to carry out their role safely.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. The practice was the only practice in Emsworth and we were told that the practice population had increased significantly in recent years. The practice building was small, meaning that GPs shared consultation rooms and this was managed using a rota system. Additional surgeries had also been introduced to reduce access times for patients to less than two weeks. The practice managed staff absences and had systems in place to cover staff who were on leave.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had panic buttons in consultation rooms which alerted staff to an emergency and other areas could activate an alarm using the practice computer system. This process was supported by a written procedure to be followed in the event of an emergency. Staff had received annual basic life support training and there were emergency medicines that were centrally located. Staff we spoke to confirmed the location of these medicines. The practice had a 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) available on the premises and oxygen with adult and children's masks. The medicines that we checked were in date and fit for use and a record of weekly checks on emergency equipment and medicines had been made.

The practice had an updated business continuity plan that provided guidance to use in the event of major incidents such as power failure.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure that all clinical staff were kept up to date. The practice had access to guidelines from NICE on the practice computer system and used this information to develop how care and treatment was delivered to meet needs. The practice monitored that these guidelines were implemented through audits and random sample checks of patients' records. For example, we saw that patient with diabetes had their condition managed in accordance with NICE guidelines and the named lead for diabetes worked closely with the hospital diabetes team. More frequent checks were carried out on patients with diabetes, including providing individual care plans.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. Results for 2013 to 2014 indicated that the practice achieved 93.85% of the total QOF points available, which is in line with national averages. This practice was not an outlier for any QOF (or other national) clinical targets.

- Performance for diabetes indicators was similar to the CCG and national average at 84.9% compared to the national average of 84.2%.
- Performance for the management of hypertension was similar to the national average, For example, the percentage of patients with hypertension having regular blood pressure checks was 84.24% compared to the national average of 83.11%.
- Performance for mental health related indicators was better than the national average, for example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had an agreed care plan documented in the record, in the preceding 12 months was 94.92% compared to the national average of 86.04%.
- Outcomes for patients with dementia were similar to national averages, For example, the percentage of patients diagnosed with dementia whose care had been reviewed in a face to face review in the preceding 12 months was 82.58% compared to the national average of 83.82%. A GP told us that patients were actively screened for dementia as part of vascular assessments and this has led to an increase in patients being diagnosed with the condition. Those that were screened as potentially having the condition were given an appointment with the GP for further assessment.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and people's outcomes. GPs had completed clinical audits as part of the revalidation process and we reviewed six clinical audits that had been completed in the last two years. We reviewed an audit of patients with suspected urinary tract infections that had been taken in response to updated guidance. An implementation of the guidance and review of patients' records indicated that by implementing and following the guidance there had been a reduction in the number of patients that required specific tests to be undertaken by 50%. Further audits had been undertaken in response to concerns raised by patients. For example, concerns were raised about a patient who suffered excessive dental caries, which had been partly attributed to their medicine which contained sugar. An audit of patients' records identified two further patients with learning disabilities that were routinely taking this medicine. These patients were invited for review and alternative sugar free medications were prescribed.

The practice used intelligence monitoring to improve outcomes for patients, For example, the practice noticed an increase in the number of hospital admissions amongst patients with cancer and this was discussed with the MacMillan nursing team who were asked to attend monthly multi-disciplinary team meetings and input into the admissions avoidance process. The practice used templates as part of the computer programme to record patients' treatments and to identify other treatment options that may improve outcomes.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safety, security, information governance and confidentiality. This was accompanied by a role specific task list that was signed when a member of staff had achieved competency in set tasks such as booking a home visit or registering new patients. There was a comprehensive staff handbook that was also available to staff on the practice computer system.
- The learning of staff was identified through a system of appraisals, meetings and review of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. For example, the nurse who was the lead for diabetes care, had been supported to attend a conference about diabetes management.
- Staff received on-going training and support. Staff were encouraged to attend learning sessions that were available during lunch times and staff who were under training received coaching and mentoring support.
- GPs had either been revalidated or were in the process of revalidation (Every GP is appraised annually, and undertakes a full assessment called revalidation ever five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). A GP registrar (a qualified doctor who is undertaking further training to become a GP) indicated that they had daily supervisions sessions at the end of each day and a named mentor they could approach for support and guidance. The practice also supported undergraduate students who were training to be doctors at Southampton University.
- All staff had annual appraisals and staff were given a form to complete in order to help them prepare for their appraisals.
- Staff received training that including basic life support, safeguarding children and adults and information management. Staff made use of external training, such as that provided by the clinical commissioning group, e-learning modules and in-house training.

Coordinating patients care and information sharing

The information needed to plan and deliver care and treatments was available to relevant staff in a timely and accessible way through the practice's patient record system and intranet system. This included care assessments, care plans, medical records and test results. Information was shared with other services in a timely way. For example, information for patients receiving end of life care was shared with the local hospice and nurses from the MacMillan cancer support organisation. Information was shared with out of hours services using the "share my care" website. Staff identified that if they received test results that were for patients registered at another practice which had been sent in error, they would contact the sender to identify this and send the results back with a compliments slip.

The practice worked with other health and social care services to understand and meet the needs of its patients and plan on-going care and treatment. This included when patients where referred or discharged from hospital. We saw that patients referred for urgent care at the hospital using the two week wait system were contacted to ensure that they had received their appointments in a timely manner.

We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. GPs used the planning ahead documentation to help patients to record their preferences for end of life care.

Consent to care and treatment

Patients consent to care and treatment was sought in line with legislation and guidance. Staff had access to policies and procedures around managing consent on their computer desktops. Consent for vaccinations was recorded in the patients' records and consent for minor surgical procedures was recorded on specific forms that identified the risks and complications that may be associated with the procedure. Staff understood the relevant consent and decision making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care and treatment was unclear the GP assessed the patient's capacity and recorded the outcome of the assessment. Staff had recorded discussions about the requirement to ensure that the patients had

Good

Are services effective?

(for example, treatment is effective)

capacity to consent to care and the importance of using the Gillick competency test (used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions) as part of their review and analysis of significant events.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients who were carers, those with learning disabilities, patients with long-term conditions, patients who were experiencing poor mental health and patients who had been identified as vulnerable through safeguarding and child protection procedures. Patients who required advice on smoking cessation, alcohol cessation and obesity management were signposted to relevant services for support and advice. Younger patients who were experiencing poor mental health were referred to services such as cognitive behavioural therapy services.

The practice had organised health promotion events that were held locally to support patients to understand conditions and other talks that were aimed at prevention of conditions. Talks had been held on diabetes, skin cancer, planning end of life care and power of attorney. A local pharmacist had talked to patients about how to use the pharmacy service appropriately. The practice had created a poster to provide information to patients about how to stay safe in the sun. GPs referred patients to a lunch club that was organised by the Patient Participation Group in order to help prevent conditions that could be attributed to social isolation.

The practice produced a quarterly newsletter called "The Quack" to provide information to patients about health advice. "The Summer Quack" provided information about exercise, including the benefits of regular exercise and how to exercise safely. The leaflet informed patients that they could be referred to local gymnasiums for assessment and six half price gym sessions if exercise would help to improve their medical conditions.

The practice had a comprehensive screening programme and provided different types of health checks to meet patient's specific needs, including new patient's checks, checks on patients over the age of 40 and medicine checks. The practice computer system had been updated to ensure that specific tests, checks and treatment could only be scheduled with an appropriate clinician and the appointment length automatically defaulted to the correct timings unless it was manually changed. The practice had a member of staff who was designated to contact patients and recall them for appropriate health checks. The percentage of women aged 25-64 whose notes recorded that a cervical screening test had been completed in the preceding five years was 91.3% compared to the national average of 81.27%.

Childhood immunisations rates for the vaccinations given were comparable to CCG averages, for example childhood immunisations rates for vaccinations given to under two year olds ranged from 76.5% to 98.1% and five year olds from 91% to 98.7%. Flu vaccination rates for the over 65s were 79.73% compared to the national average of 73.24% and the vaccination rate for at risk groups was 58.9% compared to the national average of 52.29%.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and helpful to patients and treated them with dignity and respect. Staff cared about patients and told us they knew which patients were vulnerable, frail or needed additional support and they would try and provide this. Curtains were provided in consulting rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. There was sign at reception that asked patients to wait away from the reception desk to respect the privacy of patients who were talking to reception staff. Reception staff were aware when patients wanted to discuss sensitive issues or appeared distressed and indicated that they could offer them somewhere private to discuss their needs.

The practice was situated in a small town and many of the staff knew patients well. The procedure for respecting patients' privacy was covered at staff training sessions and staff were aware that if they knew a patient well they could offer them an alternative member of staff to speak with. Patients' records that belonged to patients who had family members that worked at the practice were locked so that staff could not routinely access them and staff members chose to register at another practice. However the practice was located in an old building too small for the patients' records, which were stored in a separate building at the back of the practice. This building was locked and an alarm had been fitted to protect records but the building was not fire proof. Records storage at the branch surgery had been extended and records were being moved to the purpose built records storage facility at this location.

All of the 19 comments cards we reviewed commented positively about the care provided at the service; however one patient indicated that they sometimes find it difficult to get an appointment. We spoke with a member of the patient participation group (PPG) on the day of our visit and we were told that they were pleased with the care that was provided by staff and that staff cared about patients.

Results from the national GP survey indicated that patients were happy with the care that they received and the practice scored in line with CCG averages and above national averages for the care provided by doctors and nurses. For example:

- 90% of respondents indicated that the last GP they saw was good at listening to them compared with the CCG average of 90.1% and the national average of 88.6%.
- 88.1% of respondents said that the last GP they saw or spoke to was good at giving them enough time compared to the CCG average of 89.3% and the national average of 86.8%.
- 96.5% of respondents said that they had confidence or trust in the last GP they saw or spoke to compared with the CCG average of 97% and the national average of 95.3%
- 88.1% of respondents said the last GP they saw or spoke to was good at treating them with care and concern compared to the CCG average of 88.9% and the national average of 85.1%.
- 99.1% of respondents said the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 92.5% and the national average of 91.9%.
- 93.8% of patients said that the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 91% and the national average of 90.4%.
- 91.8% of respondents said that they found the receptionists at this surgery helpful compared CCG average of 89.7% and the national average of 86.9%.

Care planning and involvement in decisions about care and treatment

Patient feedback indicated that their health issues were discussed with them and they felt involved in their care. A member of the patient participation group told us that they felt listened to and supported by staff. Patient feedback on comments cards was positive and several of the cards indicated that patients felt that they were listened to and had the opportunity to discuss their care.

Results from the national GP patient survey we reviewed showed patients responded positively to questions about their involvement and planning and making decisions about their care and treatment and results were in line with local averages and above national averages. For example:

Good

Are services caring?

- 88.5% of respondents said that the last GP they saw was good at explaining tests and treatments compared with the CCG average of 88.4% and the national average of 86.3%.
- 84.2% of respondents said that the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and the national average of 81.5%
- 95.3% of respondents said that the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 89.9% and the national average of 89.7%.
- 89.5% of respondents said that the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 85.1% and the national average of 84.9%

The majority of the patients at the practice spoke English as a first language and staff told us that they had not needed to use a translation service. A staff member told us that if a patient did not speak English as a first language then they would be encouraged to bring a friend or relative to the appointment.

Patient/carer support to cope emotionally with care and treatment

Notices were available in the waiting room to help patients to access support groups and organisations. The practice computer system alerted GPs if a patient was also a carer and the practice had a carer's champion who had been trained to undertake this role. The carers champion told us that they were currently working with the PPG and voluntary organisations to set up a carer's clinic. Written information was available to carers to ensure they understood the support services available to them.

The PPG would visit patients who were socially isolated and encourage them to attend events. All patients had a named GP and the families of patients who were in the final stages of receiving end of life care would be given the mobile number of their named GP for support, GPs contacted families who were bereaved and visited them in order to offer support. They would also signpost those who were recently bereaved to support organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local clinical commissioning group (CCG) to plan services and to improve outcomes for patients. For example, the practice was commissioned to provide a direct enhanced service for patients with learning disabilities. Patients with learning disabilities were given an annual review and there were longer appointments available for patients who had learning disabilities. Feedback received had indicated that some patients found attending the practice for a vaccination stressful. As a result nurses visited care homes for patients with learning disabilities to administer flu vaccinations. The practice also provided other direct enhanced services such as shingles vaccinations and childhood immunisations.

Services were planned and delivered to take into account the needs of different patients groups and to help ensure flexibility, choice and continuity of care. For example:

- GPs and nurses visited patients who could not attend the surgery in their own homes at home or in care homes to provide treatment and undertake reviews such as diabetic or vascular care reviews.
- The practice provided nurse led clinics in diabetes, chronic obstructive pulmonary disorder, asthma and vascular care.
- The practice had a system of recalling patients for reviews and health checks, including those that were not included in QOF, such as checks for prostate cancer.
- The practice provided appointments outside of school hours and it was the practice procedure for children who were ill to be triaged by the duty doctor.
- The practice offered extended hours from 7.30am Wednesday to Friday and until 7pm Monday to Thursday to support patients who were at work.
- Flu vaccinations clinics were provided on Saturday mornings in order to improve access to patients who worked on weekdays.
- The practice used vascular reviews to assess patients to see if they also had dementia and patients who may have dementia were given a follow up appointment with their GP. This had increased the number of patients at the practice who had been diagnosed with dementia.
- The majority of treatment rooms and consultation rooms were on the ground floor and the practice had disabled facilities and a hearing loop.

The practice had responded to information provided by patients as part of a survey completed by the patient participation group on 24 March 2015. The survey identified that the three key areas where improvements were required included improving the telephone system so that patients would find it easier to book appointments by telephone; improving the procedure for repeat prescriptions; and improving on line access. A new telephone system had been installed; online prescribing was available for those patients who preferred to use it and the online appointment booking service had been extended.

Access to the service

The practice was open between 8am 6.30pm Monday to Friday and appointments were available from 8am to 11am and 3pm to 6pm on weekdays. Extended hours surgeries were offered until 7.30pm on Mondays, Tuesdays, Wednesdays and Thursdays and from 7.30am on Wednesday, Thursday and Fridays. The practice provided a minor injuries walk in service from 8am to 6.30pm Monday to Friday, which was open to registered and non-registered patients. Information about practice opening times was provided in the practice leaflet but this contradicted information on the practice website. For example, the practice leaflet indicated that the practice was open 7.30am to 7pm Wednesday to Friday but was open 7.30am to 6.30pm on Friday.

The practice had increased access times and in doing so had reduced the waiting time for routine appointments from two and a half weeks to one and a half weeks. The practice occasionally provided flu clinics on a Saturday morning and also visited patients for routine checks in care homes and in their own homes. A telephone triage service had also been introduced to manage high demand for appointments.

Results from the national GP survey showed that patients' satisfaction with how they could access care and treatment was higher than the local and national averages. For example;

- 90.8% of respondents were satisfied with the surgery opening hours compared to the CCG average of 77.1% and the national average of 75.7%.
- 90.5% of respondents said they found it easy to get through to the practice by telephone compared to the CCG average of 84.3% and the national average of 74.4%

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 88.8% of patients describe their experience of making an appointment as good compared to the CCG average of 79.8% and the national average of 73.8%.
- 79% said they usually wait 15 minutes or less after their appointment time to be seen compared to the CCG average of 61.5% and the national average of 65.2%.
- 100% of patients said the last appointment they got was convenient compared to the CCG average of 94.1% and the national average of 94.1%.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system in the practice, on the practice website and in the practice booklet. The practice procedure was to invite patients in to discuss their complaint with the complaints manager. Reception staff were able to provide us with a specific leaflet that outlined the complaints procedure.

We looked at nine complaints that had been received in the last 12 months and found that each complaint had been recorded with the details of any lessons learned. Complaints had been satisfactorily handled, dealt with in a timely way, with openness and transparency. Complaints were discussed at the practice meeting that was held annually to discuss significant events. Information about complaints was shared with staff at other meeting but this was not recorded. Action had been taken in response to complaints received, including disciplinary action against staff if needed.

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 did not have a documented vision and strategy but a patient's charter was available in the practice and in the practice booklet. The charter outlined the level of service that patients could expect from the practice such as being treated with courtesy and respect and being offered appropriate advice regarding steps to promote good health and avoid illness. The charter also outlined the expectations from patients such as extending the same courtesy and politeness towards staff that they would expect to receive themselves.

Governance arrangements

There was an overarching governance framework which supported the delivery of good quality care. The practice had policies, procedures and governance arrangements in place. For example,

- Staff that were recruited had received appropriate checks such as references and had been given enough information to undertake their own roles and responsibilities.
- Clinical audits were undertaken which were used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, and implementing actions to reduce risks to patients and staff. .
- Significant events and complaints were investigated and responded to appropriately with lessons learned being recorded.

However there were no health and safety audits available and the practice had not completed internal audits of infection control but had taken advice from the Clinical Commissioning Group infection control lead who had undertaken an external audit. The practice had responded to the findings of this audit and taken action to make improvements as a result of the findings.

Leadership, openness and transparency

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. The practice prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us that they were approachable and always made time to listen to staff. Staff said that they felt respected, valued and supported. Staff were encouraged to identify opportunities to improve the service delivered and to identify any areas where improvements could be made.

Team meetings were held and minuted on a quarterly basis and the 'lessons at lunchtime' learning events were open to all staff. Doctors who were training to become GPs were given extended appointments and supported by a mentor. Staff were supported to undertake additional training that was relevant to their role. For example, the lead nurse for infection control had attended update training in infection control on 1 July 2015.

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

The practice encouraged and valued feedback from patients and engaged patients in the delivery of services. The practice had completed a recent survey through the Patient Participation Group and had responded to information that had been received by making improvements to the service such as the introduction of a new telephone service. A report was available that had been produced following the 2014 PPG survey which outlined actions that had been taken in response to the information received and information was shared with patients using the practice newsletter. The practice also gathered information through staff appraisals and discussions. The practice asked staff to identify five things about their work that had kept them awake at night. This information had been discussed with staff to improve their quality of their life and reduce workplace stress. Staff told us that they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that they felt involved and engaged to improve how the practice was run.