Brockhurst Medical Centre

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

This was a comprehensive inspection of the Brockhurst Medical Centre which was carried out on 9 December 2014.

We rated this practice as good overall. The practice was well led by the senior GP partner and the practice manager who provided a caring, compassionate service.

Our key findings were as follows:

- The practice was visibly clean and there were systems in place to maintain an appropriate standard of cleanliness and hygiene.
- The practice was rated highly by patients for the respect they were shown and for the kindness and consideration shown by reception staff.
- The practice provided GP appointments at times that met the needs of their patients with same day appointments or telephone consultations. Some appointments were available until 7.30pm for patients who could not attend during working hours.
- The latest patient satisfaction survey showed that 90% of the patients that responded rated their overall experience of the practice as either good or excellent. The practice had recently been awarded GP practice of the year based on the positive comments that they received from patients registered at the practice.
- The practice GPs met with the school nurse and health visitor every six weeks to keep each other informed of any safeguarding issues or vulnerable patients.

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

The provider should:

- Have a policy for the management, testing and investigation of Legionella.
- Have a system in place to record the Hepatitis B immune status of GPs and nurses.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses.

Appropriate arrangements were in place in relation to obtaining medicines and vaccines, Emergency medicines and associated equipment was available for use and regularly checked to ensure it was in date and suitable for use. Arrangements were in place to deal with emergencies and major incidents

A detailed business continuity plan was in place to deal with any event which may cause disruption to the service. There were enough staff to keep people safe. The practice had recruitment procedures in place which appeared to be consistently followed.

Are services effective?

Good

The practice is rated as good for effective. Our findings at inspection showed the practice delivered care and treatment in line with recognised best practice. They worked with other health professionals to ensure a complete service with the right treatment outcomes for their patients.

The provider had systems and processes in place to ensure that standards of care were effectively monitored and maintained. Clinical audit cycles had been completed, which had resulted in improvements to patient care and treatment.

Patients were supported to manage their own health and were treated by appropriately trained staff. In most cases staff received the necessary support, training and development for their role and extended duties. However we found some gaps in refresher staff training in areas such as safeguarding and infection control.

Are services caring?

Good

The practice is rated as good for caring.

The patients we spoke with and the comment cards we received were positive about the care provided. Patients told us they were treated with respect and their privacy and dignity was maintained. Care was taken to ensure patients' confidentiality was protected.

Patients said they were given sufficient time to discuss their problem or treatment options and were referred to other health care professionals when needed.

Summary of findings

Arrangements were in place to support patients who were nearing the end of their life and regular contact was maintained with palliative care teams.

The practice had recently been awarded GP practice of the year by a local newspaper who selected the surgery as the winner based on the positive comments that they received from patients registered at the practice.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and worked with other services to improve the service for patients. Patients reported good access to the practice with urgent appointments available the same day.

The practice and was equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

The reception staff knew patients well and were able to alert GPs to any concerns they may have about individual patients.

Are services well-led?

Good

The practice is rated as good for being well-led. There was a clear leadership and staff felt supported by the senior GP partner and practice management. The practice had a number of policies and procedures to govern activity and systems in place to monitor and improve quality and identify risk. However the systems in place did not ensure that staff training was appropriately monitored shortfalls acted upon.

The practice proactively sought feedback from patients, which it acted on. The practice had an active patient participation group.

Staff had received induction, regular performance reviews and felt communication throughout the practice was good.

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 the practice had good outcomes for conditions commonly found amongst older people. There was good communication with other health care providers to ensure the needs of these patients was met. For example the practice worked closely with the community nursing team and palliative care team to ensure good provision of end of life care.

Each patient over 75 years of age had a named GP but were able to see any GP of their choice for continuity of care. We saw that the practice responded to the needs of this population group by improving access to the services they needed. Home visits were arranged if necessary with a direct telephone line available for care homes. The electronic record system alerted staff if a patient had a carer or if they had caring responsibilities.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice was aware of those patients with long term conditions and had processes in place to make urgent referrals to secondary care should it be necessary or when longer appointments or home visits were needed. All these patients had structured annual reviews to check their health and medication needs were being met.

Administration staff were responsible for tracking certain streams of information such as asthma and chronic obstructive pulmonary disease (COPD) and inviting patients into the practice for health checks.

Families, children and young people

Good

The practice was rated good for the care of families, children and young people. The practice had a GP partner with an interest in family planning and child health and they were the lead for child safeguarding.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. There was a system in place to encourage the uptake of vaccination for five year old children. A member of

Summary of findings

reception staff worked closely with the practice nurse to repeatedly contact parents to offer vaccinations. The practice alerted health visitors to those children who continually missed appointments for their immunisations in order to ensure the safety of the child.

There was flexibility in the appointment system to ensure that ill children were always seen the same day. Patients told us that children and young people were treated in an age appropriate way and recognised as individuals.

Health visitors and the school nurse attended the practice's community liaison meetings to discuss any child protection issues or families in vulnerable circumstances.

Working age people (including those recently retired and students)

Good

The practice was rated good for the care of working age people (including those recently retired and students). Evening surgeries were available for patients. This increased the accessibility of their service to people who were unable to attend during the day due to work commitments.

The practice had proactively promoted the use of on line appointment booking and on line ordering of prescriptions. Patients were also able to use a smart phone application to make appointments. There was capacity within the appointment system for all patients to be seen the same day or to have a telephone consultation.

People whose circumstances may make them vulnerable

Good

The practice was rated good for people living in vulnerable circumstances. The practice provided health checks for their patients who had a learning disability and lived in the community. Data showed that all patients with a learning disability had received a health check within the last 12 months.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. .

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia).

Summary of findings

The practice population included a number of veterans (ex-service personnel) who were at risk of post-traumatic stress disorder (PTSD). The electronic system highlighted to staff and GPs those patients who were veterans.

Patients experiencing poor mental health were signposted to other support organisations. Patients were referred to a local counselling service by GPs and staff were trained to direct patients to the service directly if necessary in order to make a self-referral.

Summary of findings

What people who use the service say

We spoke with nine patients on the day of our inspection. We reviewed 21 comment cards which had been completed by patients in the two weeks leading up to our inspection.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions, people with a diagnosis of poor mental health and people aged over 75 years of age.

Generally patients were very complimentary about the practice staff who they said were friendly, understanding and supportive. All except one of the patients we spoke with praised the practice for their ability to provide an appointment promptly. Four of the patients we spoke with had called that morning and had been given an appointment. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines in a way they could understand.

The last patient survey was conducted by the practice in October 2013 the results from this survey showed that the practice was rated higher than the national average for patient satisfaction. Results from the 2013 GP survey also showed that just over 90% of those patients surveyed felt that their overall experience of the practice was either good or very good.

Areas for improvement

Action the service SHOULD take to improve

- The practice should have a policy for the management, testing and investigation of Legionella.
- Have a system in place to record the Hepatitis B immune status of GPs and nurses.

Brockhurst Medical Centre

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, a specialist advisor in practice management and a member of CQC's National Customer Support Centre staff.

Background to Brockhurst Medical Centre

Brockhurst Medical Centre is located at 139-141 Brockhurst Road, Gosport, Hampshire PO12 3AX. The practice is on the Gosport peninsula on the western side of Portsmouth harbour. Brockhurst Medical Centre is part of the Fareham and Gosport Clinical Commissioning Group (CCG). The practice operates from converted residential premises which are owned by the GP partners. The practice building has four consulting rooms, a treatment room and an examination room.

The practice does not provide an Out of Hours service for their patients. Outside normal surgery hours patients are able to access urgent care from an alternative Out of Hours provider.

The practice provides a range of primary medical services to approximately 4,300 patients. Patients are supported by one female (full time) GP partner and one male (part time) GP partner, a female salaried GP and a male salaried GP also a long term locum GP. The GPs in total provide the equivalent of 2.5 full time GPs. Further support is provided by a practice manager, a non-clinical partner, three practice nurses and a nurse practitioner, administrative and reception staff.

Brockhurst Medical Centre has a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

Fareham and Gosport CCG covers a less deprived area than the average for England. Brockhurst Medical Centre covers an area equal to the least deprived 40% of England.

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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the local NHS England, Healthwatch and the Fareham and Gosport Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 9 December 2014. During our visit we spoke with a range of staff including

Detailed findings

four GPs working at the practice that day which included a locum GP, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 21 comment cards where patients and members of the public had shared their views and experiences of the service. We also reviewed the practice website and looked at information posted on 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 living in vulnerable circumstances
- 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 in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff were aware of their responsibilities to report incidents and near misses. For example staff had worked together to put in place procedures to avoid mistakes relating to sharing or recording information for patients who shared the same name.

We reviewed safety records and incident reports and minutes of meetings where these reports were discussed. We reviewed the significant events that had been recorded by the practice over the last 12 months. We saw that safety incidents had been acted on promptly and action had been taken to mitigate future risks. There was evidence that significant events had been handled appropriately to protect the safety and well-being of patients.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. The records for the last 12 months were made available to us.

Significant events were discussed at each practice meeting additionally the practice held an annual meeting to discuss significant events and complaints received during the year. There was evidence that changes were made to practice as a result of incidents and complaints and those findings were disseminated to relevant staff verbally or through staff meetings. Systems within the practice had been changed to minimise future risks. We saw minutes of meetings, where significant events had been discussed. An annual significant review meeting reviewed the actions taken and discussed how change was monitored.

For example to ensure that information was added to the correct patient record, when patients with the same or similar name were registered at the practice. A number of checks had been put in place which included alerts on the electronic records of patients with the same or similar names and reminders posted by the scanner to ensure reception staff were checking dates of birth.

National Patient Safety Alerts were disseminated to practice staff as soon as they were received by the practice. Any patient safety alert was emailed to all staff with a copy kept in reception. However there was no method of recording that the safety alert had been seen or acted on by GPs or other staff.

Reliable safety systems and processes including safeguarding

The practice's electronic record system ensured risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. All the GPs at practice had received training in child and adult safeguarding which included level three training in child safeguarding. Staff knew how to access the practice safeguarding policy, which GP look the lead for safeguarding and who to speak to in the practice if they had a safeguarding concern. The details of local safeguarding teams were prominently displayed for staff should they need to contact them to make a referral or for help and advice. Staff were aware of their responsibilities to report any concerns they may have.

Practice nurses' training in relation to safeguarding children was undertaken over two years ago, there was not any record of them receiving adult safeguarding training. We reviewed staff files and found that all other staff had received training in safeguarding adults and children.

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who accompanies another person to protect them from inappropriate interactions during treatment or examination). Nursing staff or GPs acted as chaperones when required.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic software system for primary healthcare, which collated all communications about the patient including scanned copies of communications from hospitals. We saw that the practice had a system in place to ensure that the senior GP partner or another GP partner saw all practice correspondence each day so immediate action could be taken if necessary.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely

and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential refrigerator failure.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available; in date and ready for use should they be needed. Expired and unwanted medicines were disposed of in line with waste regulations. However we did note that there were two topical medicines (topical medicines are medicines that are applied to the skin, for example creams) stored in a consulting room which were out of date.

We saw that the practice had a prescribing action plan which had been agreed with the clinical commissioning group (CCG) medicines management team. The aim of the action plan was to improve outcomes for patients and to promote cost effective options and ensure prescribing was in line with national institute of health and clinical excellence (NICE) guidance. For example the practice had audited the use of a medicine to ensure patients continued to benefit from the therapy.

Vaccines were administered by nurses using patient group directions that had been produced in line with national guidance. We saw evidence that the practice nurses had received training to administer vaccines however records showed this training had taken place more than 18 months ago.

Patients were able to request repeat prescriptions at the practice, the local pharmacy or online, patients we spoke with did not have any concerns about the process. The practice had a protocol for repeat prescribing which was in line with GMC guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medications to ensure the medication was still safe and necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescriptions were stored securely.

Cleanliness and infection control

We observed the premises to be visibly clean, tidy and well maintained. We saw that a cleaning regime was in place for each room of the practice. Work surfaces could be cleaned easily and were clutter free. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had recently appointed a nurse to lead on infection control. They had taken part in infection control training before taking up employment with the practice however at the time of our inspection had not taken part in further training to enable them to provide advice on the practice infection control policy or carry out staff training. Since their appointment the lead in infection control had carried out an audit of the infection prevention and control practices, produced an annual infection control statement and reviewed the infection control policy. They demonstrated they knew their responsibilities in relation to their role. Minutes showed that the infection control lead had used to practice meeting to remind staff about good practice. Nurses at the practice had been trained in infection control however training records showed that GPs had not completed training in any aspect of infection control.

An infection control policy and supporting procedures were available for staff to refer to. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury.

We saw there were appropriate waste disposal procedures in place in the treatment room with appropriately labelled clinical waste bins and medicines and sharps waste containers. The practice had a contract with a waste disposal company to collect and dispose of clinical and medicines waste.

The practice did not have a policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). The practice building had a system for storing water, the risks to patients and staff from Legionella had not been formally assessed.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly. We saw that medical equipment had been calibrated and was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use. Further calibration and PAT testing was scheduled for August 2015.

Good

Are services safe?

Staffing and recruitment

The practice staff consisted of two GP partners and a non-clinical partner plus two salaried GPs and a long term locum GP. These staff provided sessions equal to approximately 2.5 full time GPs. There were also three practice nurses and a nurse practitioner which provided nursing hours equal to approximately 1.5 full time nurses.

We looked a sample of recruitment files and found that appropriate checks, including a criminal records check, such as through the Disclosure and Barring Service and satisfactory evidence of employment in previous jobs had been obtained. Nurses' registrations were checked to ensure they were current. The practice completed General Medical Council checks on GPs and locum GPs, but relied on the checks made by the locum agency of any locum GPs they employed through them. We saw that the practice did not have a record of the Hepatitis B status of all their GPs and nurses. The practice manager collected the information from the practice nurses and told us within 48 hours of the inspection that they were aware of the nurses' immune status. We noted that for one nurse a retest had been recommended but not carried out.

The majority of administration and reception staff had worked at the practice for a number of years, the practice manager and GP partner told us they felt the stable work force provided a safe environment for their patients. The reception staff knew patients well and were able to alert GPs to any concerns they may have about individual patients.

We saw there was a rota system in place for the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of administrative staff and reception staff to cover each other's sickness or annual leave.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment and emergency alarms. Fire extinguishers were checked annually and staff underwent annual training in fire safety. The practice manager carried out a health and safety audit every 12 months.

The practice ensured that appropriate risk assessments were carried out in relation to both patients and staff. For example a risk assessment had been carried out to assess the risks to a member of staff during their pregnancy.

There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records to show that all staff had received training in resuscitation in line with recent requirements of the Quality and Outcomes Framework (QOF). All staff asked, knew the location of the automatic external defibrillator (AED) a machine which is used in the emergency treatment of a patient suffering a cardiac arrest, oxygen, and emergency medicines.

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. Processes were in place to check emergency medicines were within their expiry date and suitable for use. A practice nurse checked the emergency medicines to ensure they would be safe to use should an emergency arise.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The practice had established relationships with two local GP practices. They had reciprocal arrangements in place to use their facilities which would allow them to continue to provide patient care should they not be able to operate from their current premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff at the practice were responsible for patients' chronic disease management, for example diabetes and asthma.

We found from our discussions with the GPs and nurses that they completed thorough assessments of patients' needs in line with current guidelines and these were reviewed when appropriate. We saw that an audit on patients at risk of ischaemic stroke was used to identify those patients who may benefit from the use of anticoagulant therapy.

GPs and nurses remained up-to-date in most areas by attending courses in subjects relevant to their practice. We were able to see the records kept by the practice manager of all training courses and educational meetings they had attended. All the GPs and nurses interviewed were aware of their professional responsibilities to maintain their professional knowledge and skills.

The practice referred patients appropriately to hospital and other community care services. National data showed the practice was in line with national standards on referral rates for all conditions. All new patients to the practice were offered a health assessment carried out by the practice nurse to ensure the practice was aware of their health needs. Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. As the practice relied on part time GPs and locums the senior GP or their GP partner ensured they checked all the test results returned to the practice. This ensured that if a GP was not available any results could be acted on at once to avoid any delay to the patient.

The practice provided specialised appointments to meet the needs of patients. These included diabetes, asthma and chronic obstructive pulmonary disease (COPD), a disease which results in breathing difficulties. These specialised appointments were carried out by the practice nurses, who had undertaken further relevant training, with support from the GPs. There were arrangements in place to ensure all patients with a long term medical condition received an annual health check.

The practice was aware of the top 2% of their patients at most risk of frequent hospital admission. Care plans had been produced for each of these patients. The practice used computerised tools to identify patients with complex needs. The practice held monthly GP meetings and monthly gold standards framework meetings. (Gold standards framework is a systematic, evidence based approach to providing the optimum care for all patients approaching the end of life.) There were also meetings every six weeks with the school nurse and health visitor. These meetings were used to discuss patients who had complex health and social care needs. As the GPs at the practice were mostly part time they did not all attend, information from the meetings was sent electronically to those staff you could not attend

Management, monitoring and improving outcomes for people

The practice collected information about patients' care and outcomes. The practice undertook clinical audits and the Quality and Outcomes Framework (QOF) was used to assess the practice's performance. (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries.)

The practice regularly reviewed their achievements against QOF. The practice had links with neighbouring practices who they worked with to identify best practice and improve outcomes for their patients. The QOF data was actively monitored at the practice and GPs were made aware of any shortfalls that needed to be addressed. Administration staff were responsible for tracking progress against QOF, they were able to tell us how the practice was progressing towards their identified targets. QOF data showed the practice performed well in comparison to local practices.

The practice collected information about patients' care and the effectiveness of treatments. They used QOF to assess performance and completed the clinical audits that were required to fulfil the requirements of QOF. We saw evidence of complete clinical audit cycles one of which showed the practice had assessed the benefits of identifying and treating patients at risk of calcium and vitamin D deficiency, in line with national guidelines. As these were

Good

Are services effective?

(for example, treatment is effective)

known contributory factors in the development of osteoporosis. The practice had also worked with the clinical commissioning medicines management team to audit prescribing for patients with a variety of conditions to ensure it followed current best practice guidelines. Following the audits the findings had been discussed by the practice GPs and the agreed actions recorded.

The practice checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and lung disease. The practice continued to provide regular health checks for patients suffering from epilepsy, despite it no longer being a requirement of their QOF target.

The IT system flagged up relevant medicines alerts when the GP prescribed medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs. We noted that the most recent overall QOF (2013/2014) score for the practice was 96.9%, which is slightly higher than the national average. Other areas where performance was comparable to the national average included uptake of immunisations.

We found that regular NHS health checks were offered to identify potential health conditions which gave GPs and nurses opportunity to work proactively with patients about how to manage their health. For example, health checks for those aged 40-74 years. We also saw that patients outside this age range could have a health check if they wanted.

The practice held palliative care registers and met with other health care professionals monthly to discuss patient care. Meetings were held every six weeks with other health professionals such as the school nurse and health visitors to discuss the needs and treatment of patients. The practice was able to show us the data which showed that patients with learning difficulties had received a comprehensive health check in the previous 12 months and the practice had carried out 100% of the cytology screening for their target group.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that there were some gaps in the training of staff.

Staff told us that they took part in training organised by the practice. For example GPs attended target events organised by the clinical commissioning group and the practice organised specific in house training for the other staff. Recent training had included managing medicines and how to deal with challenging patients. The practice nurses had attended training or gained further qualifications in subjects such as, wound care, asthma, mental health and cytology.

We noted that training in some areas had not taken place recently. For example training in safeguarding for the practice nurses had been over two years ago and this had only covered safeguarding children. In addition there were no clear dates of when further training or refresher training was needed. We saw evidence that the practice nurses had received training to administer vaccines however records showed this training had taken place more than 18 months ago. Nurses at the practice had been trained in infection control however training records showed that GPs had not completed training. Other shortfalls in staff training showed that not all staff had received training in information governance, equality and diversity and the Mental Capacity Act.

We saw records to show that all staff had received training in resuscitation. Although we noted the training was for most staff over 12 months ago. The date recorded for refresher training was not in line with the frequency suggested by the resuscitation council.

All the staff we spoke with in both nursing and administrative roles told us they were well supported by the senior GP partner and the practice manager. There was an annual appraisal system in place for staff. Staff told us they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. Staff also told us that due to the small size of the practice and the close working relationship between all staff they were constantly making suggestions for the smooth running of the practice and discussing their development needs.

GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC). All GPs were aware of their appraisal schedule and revalidation dates. (Every GP is appraised annually and every five years undertakes a

Good

Are services effective?

(for example, treatment is effective)

fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Working with colleagues and other services

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to meet regularly with the GPs to discuss the needs of their patients.

Antenatal and postnatal care was provided by community midwives based at the local hospital and health visitors who were based at a nearby children's centre. The senior GP partner provided postnatal care at the practice and had links with the midwives and health visitors for the shared care of their patients. The practice held monthly multidisciplinary meetings to discuss the health and social needs of patients at the end of life these were attended by health care professionals as appropriate. The practice GPs met with the school nurse and health visitor every six weeks to keep each other informed of any safeguarding issues or vulnerable patients.

There were systems in place to ensure that the GPs reviewed communication from other health care providers, for their patients. 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 procedure for all relevant staff for passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Administration staff collated information in a variety of formats from the Out of Hours provider or from other organisations. All information was collated and passed to the senior partner GP or another GP in their absence. Immediate action was taken if required; including for those patients whose GP was not available that day. All staff we spoke with understood their roles and felt the system that was in place worked well.

Information sharing

Patient information was stored securely on the practice's electronic record system. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. We saw that information was transferred to patient records promptly following out of hours or hospital care. The practice retained historic paper patient records which were stored securely and used if necessary to review medical histories.

The practice ensured that the Out of Hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they would implement it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes. Although staff were able to describe the principles of the Mental Capacity Act 2005 when assessing whether a patient was able to give informed consent, they had not received specific formal training on this subject, which the practice acknowledged.

There was a practice policy for documenting consent for specific interventions. For example, for some family planning procedures. Verbal consent was documented in the electronic patient notes with a record of relevant discussions.

Patients said that they felt involved in decisions about their care and treatment. They said they were given time to consider options available and were never rushed. One parent told us that the GPs had involved their child in conversations and spoke with them and explained things in an age appropriate way. Another patient told us the GP had printed information for them which made them feel very well informed about their proposed treatment.

Health promotion and prevention

All new patients to the practice were offered a new patient medical with the practice nurse to ensure the practice was aware of their health needs. The GP was informed of any health concerns identified and these were followed-up in a timely manner. One patient who was new to the practice told us that they had been given plenty of time at their

Good

Are services effective?

(for example, treatment is effective)

health check to ask questions and had been given information about a healthy lifestyle. GPs and nurses used their contact with patients to help maintain or improve mental and physical health and wellbeing. For example, by offering smoking cessation advice to smokers and promoting appropriate health screening. Practice data showed they had offered quit smoking advice and support to 76% of their identified smokers. Systems were in place to identify at risk groups such as those that required specialist health screening or patients who had chronic disease. These groups were offered further support in line with their needs.

The practice had a range of health promotion leaflets in their waiting room and noticeboards were used to signpost patients to relevant support organisations. A selection of health promotion information was also available on the practice website.

Practice nurses had specialist training and skills, for example in the treatment of lung disease, diabetes and travel vaccinations. The practice offered a travel vaccination service. This enabled nurses to advise patients about the management of their own health in these specialist areas. 83% of patients on the practice's chronic disease register had received advice and support from either a GP or nurse in relation to the management of their condition.

The practice had a good knowledge of all their patients with a learning disability. Patients with a learning disability were offered a physical health check; practice data showed that all these patients had received a health check in the past 12 months.

The practice offered a full range of immunisations for children and data showed that the practice had immunised a high percentage of eligible children. The practice offered flu vaccinations in line with current national guidance. Patients told us that the practice publicised the vaccinations well.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with nine patients and reviewed 21comment cards. All patients were complementary about the care that they received from all the practice staff. We spoke with patients of varying ages. They all said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey, NHS Choices and the practice's latest satisfaction survey conducted in October 2013. The evidence from all these sources showed patients were very satisfied with how they were treated and described the staff as polite, courteous and helpful. The practice survey showed that 90% of those who responded rated their overall experience of the practice as either good or excellent. The majority of patients told us that the GP or nurse they saw listened to them and gave them enough time during their consultation, they did not feel rushed.

Staff told us how they respected patients' confidentiality and privacy. Some telephone calls were made and answered by staff who were not sitting at the reception desk this helped keep patient information private and ensured that confidential information could not be overheard. During our observations in the waiting room we did not overhear any personal information. A radio playing also helped to distract from conversations at reception. Some reception staff had taken part in information governance training in March 2012 and a date for refresher training in March 2014 had not taken place, there was no record of training for some reception and administration staff. Those we asked were able to demonstrate how they ensured patients' privacy and confidentiality was maintained.

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

Care planning and involvement in decisions about care and treatment

Patients said that they were given enough time to discuss their concerns and were given clear information about treatment options open to them. Patients we spoke with on the day of our inspection told us that their GP explained their treatment and all commented that there was enough time to discuss their needs. They also told us they felt listened to and supported by staff. They understood what had been said in order to make an informed decision about the choice of treatment they wished to receive. The comment cards we received were also positive and praised the polite and professional attitude of staff.

Patient/carer support to cope emotionally with care and treatment

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs and ensured they received specific patient notes. This included individualised information about patients' complex health, social care or end of life needs. The practice supported their patients with end of life care in their own home if it was the patients wish to die at home rather than in hospital.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required.

Indicators were on patients' records to show whether the patient had a carer or was cared for by another person. This system alerted GPs to provide information available for carers to ensure they understood the various avenues of support available to them. The practice website gave carers information about the support available to them and those they cared for.

Notices in the patient waiting room told people how to access a number of support groups and organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Whenever possible patients were offered the GP of their choice. All patients over 75 had a named GP in line with current recommendations.

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. The practice had responded to the needs of the practice population.

The practice had a number of patients of working age. Extended hours opening until 7.30 pm were available every Monday, Tuesday and alternate Wednesday for patients who could not attend during working hours due to work commitments; nurse appointments were available each day until 6.30pm. Lunchtime appointments were also offered if patients needed to be seen by a GP the same day. During our inspection we spoke with nine patients and reviewed 21 comment cards, most commented positively on the availability of appointments, how quickly their telephone calls were answered and waiting times once they were at the practice.

The practice worked collaboratively with Fareham and Gosport Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. Two of the practice's established GPs had retired from the practice and recruitment to their positions had not been possible. The practice had worked towards providing patients with consistent care from long term locum and salaried GPs. They had worked collaboratively with local GP practices to provide the services their patients required such as sharing resources to enable patients to have phlebotomy services (have blood taken for testing).

The practice had a patient participation group (PPG). The practice's patient feedback survey had been designed based on the priorities identified and agreed by the practice and the PPG. The PPG had been consulted about the questions for the annual patient survey carried out in October 2013. Following the survey the PPG and the practice had met to discuss the findings of the survey and suggested areas of change. We saw that a number of actions had been recorded such as investigating the possibility of lowering part of the of reception counter to help wheelchair users access reception and providing wheelchair ramps for the back door. We saw that some of the actions were complete while other actions had no date for completion or record of progress. A member of the PPG made themselves available to the inspection team and were keen to promote and compliment the responsiveness of the practice. They explained how they worked with the practice for the benefit of patients. PPG meetings were attended by the practice manager.

Tackling inequity and promoting equality

The practice had suitable arrangements in place to protect patients' confidentiality. Staff we spoke with were aware of Gillick competence when asked about treating teenage patients. (Gillick competence is a term used in law to determine whether a patient aged under 16 is able to consent to their medical treatment, without the need for parental permission or knowledge).

The practice premises were accessible to patients who were wheelchair users or required walking aids.. The reception desk was at a high level which could represent a barrier to patients who used wheelchairs.

Baby changing and disabled toilet facilities were available and all consulting rooms were on the ground floor.

Staff had access to a language line if needed for patients whose first language was not English and needed an interpreter.

Access to the service

The practice was open at 8am to 7.30pm Monday, Tuesday and alternate Wednesdays and until 6.30pm Thursday and Friday. The practice did not close at lunchtime and appointments were available from 8.15 am. Routine appointments could also be booked on line or by mobile telephone using a telephone application called Patient Access. Patients were able to access same day appointments if medically necessary but those we spoke with understood that if they wanted to see a specific GP there may be a wait of a number of days.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

Longer appointments were also available for people who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed them.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, four of the patients we spoke with told us they had contacted the practice that morning and had been given their appointment. One parent of a young child had called the practice at 11am and had been given an appointment within the hour. They were pleased that their sick child had been prioritised for an urgent appointment.

Listening and learning from concerns and complaints

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

Accessible information was provided to help patients understand the complaints system this was set out in the practice leaflet, on the practice website and displayed in the practice. Patients were asked to put complaints in writing but there was information about verbal complaints or how people could be supported if they wanted to make a complaint.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed that the practice responded quickly to issues raised. The record of complaints showed that all complaints had been responded to in a courteous manner by the practice manager. Any comments made about the practice on the NHS Choices website had been responded to by the practice manager, either thanking the patient for their positive comments or encouraging the patient to approach the practice to allow them to address their concerns. The practice regularly analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback. It had recently been decided that complaints would be on the agenda for every practice meeting.

There was evidence of shared learning from complaints with staff. We noted from minutes of meetings and by talking with staff that complaints were discussed to ensure all staff were able to learn and contribute to improvements at the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver a caring service for their patients. Their ethos was to promote an open culture and teamwork where each person played their role.

We spoke with three GPs, a practice nurse, the practice manager and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these.

All staff felt able to make suggestions to improve outcomes for patients for example in relation to improving attendance for annual health checks.

The two GP partners met monthly and invited the other GPs. However due to some of the GPs working part time hours there were few occasions when they all attended to share and discuss information to improve effective patient care.

The practice worked with nearby practices to share resources and improve services for their patients. Patients described the practice as caring and friendly.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. The practice held annual governance meetings; additionally significant events and complaints was a regular agenda item for monthly practice meetings. We saw minutes of practice meetings which showed that performance, quality and risks were discussed.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and to monitor the effectiveness of some aspects of the practice. The QOF data for this practice showed it was a high performing practice within the Fareham and Gosport Clinical Commissioning Group (CCG). Administration staff told us they had regular discussions with the senior GP partner, who was the lead for QOF, to ensure they were constantly aware of the practice performance.

The practice manager told us that they met with other practice managers from the Gosport area each month and with practice managers from the whole CCG three times a year. This gave the practice the opportunity to measure their service against others and work collaboratively to identify best practice.

Clinical audits were undertaken by the practice GPs. We saw evidence of completed audit cycles.

The practice manager and GP partners demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality. However the systems in place did not ensure that staff training was appropriately monitored and shortfalls acted upon.

Leadership, openness and transparency

The practice had clear leadership from the senior GP partner who took the lead in most areas, for example; safeguarding and complaints and oversaw all clinical practice. Practice nurses took the lead in managing chronic disease and there was a lead nurse for infection control.

Monthly practice meetings were not attended by all GPs. However the partner GPs cascaded information to colleagues who told us they felt well informed and that communication within the practice was good.

The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing non-clinical staff whose roles were in reception or administration. The leadership was established at the practice as the senior GP partner had been in their role for a number of years. They continued to ensure they had a good oversight of the practice and patients. All the staff we spoke with told us they felt very well supported by the GP partners and the practice manager.

All staff confirmed there was an open culture and felt able to go to any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and that they were provided with opportunities for development and training, appraisals were carried out annually. Although we found there were some gaps in the training of staff in certain areas. Staff informed us that communication within teams and across the service was good with information shared appropriately and that they felt valued.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example the recruitment policy, data protection and health and safety, which were in place to support staff.

Are services well-led?

Good

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

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

The practice had gathered feedback from patients through a survey carried out with the patient participation group (PPG), the NHS Choices website and patient compliments and complaints.

We looked at the results of the latest patient satisfaction survey carried out in October 2013 90% of the responses had rated their overall experience of the practice as good or excellent. We saw that some changes had been made to the practice as a result of feedback. Progress on other actions had not been recorded, although the representative from the PPG told us that they had been kept informed about the changes the practice were still considering. PPG members spent time in the practice and had been responsible for updating the waiting room noticeboard to make it more attractive and relevant to patients. They said they introduced themselves to patients in the waiting room and encouraged feedback.

There had been 257 responses in the patient survey which was conducted over two weeks in October 2013. The survey questions had been developed collaboratively with the PPG. Discussions had taken place to decide the most appropriate way to reach patients who did not attend the practice on a regular basis. Questions were focused on patient experience of the practice, GPs and nurses and access to GP consultations. The practice manager showed us the analysis of the survey which had been developed and discussed with the PPG. The results and actions of the survey were not available for patients on the practice website.

Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff electronically.

Management lead through learning and improvement

GPs and nurses told us that the practice supported them in their clinical and professional development through training and mentoring. We saw that regular appraisals took place and examples where staff had been encouraged to complete specialist training for their role. Staff told us that the practice was very supportive of training and where possible training took place at the practice. However we saw record of staff training which showed that training and refresher training for staff was not always up to date.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally as appropriate to ensure the practice improved outcomes for patients. For example staff had the opportunity to reflect on a medical emergency that had taken place. Staff told us they were able to contribute to the learning process and to make suggestions for future training. The practice had supported staff following the incident and had acknowledged their professional and efficient actions.