Dr K. Davidson & Partners

Quality Report

Waterside Health Centre, Beaulieu Road, Hythe,
Hampshire. SO45 5WX
Tel: 02380855955
Website: www.redandgreenpractice.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 a comprehensive inspection on 5 November 2014. During our visit we inspected the services provided from Waterside Health Centre, we did not visit the branch surgery at Blackfield Health Centre. The practice provides training for GP registrars and medical students.

Overall the practice provided a good service for patients.

Our key findings were as follows:

- Patients were able to access same day appointments.
- Patients were treated with dignity and respect and involved in their treatment.
- Each patient had a named GP to promote individualised care.
- Infection control processes were robust and minimised the risk of cross infection.
- The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were incorporated in the day to day running of the practice.
- The practice had robust systems in place to ensure there were always sufficient staff to provide the service; this included forward planning to cover annual leave requirements.
- Patients benefited from an active approach of the practices' involvement with a separate organisation of 17 GP practices. For example a new phlebotomy service was due to commence in January 2015.

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

The provider should

- The practice should ensure that all staff have relevant safeguarding training for adults as well as children appropriate to their role.

We carried out a comprehensive inspection on 5 November 2014. During our visit we inspected the services provided from Waterside Health Centre, we did not visit the branch surgery at Blackfield Health Centre. The practice provides training for GP registrars and medical students.

Summary of findings

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. Information about safety incidents was recorded, monitored, appropriately reviewed and addressed. Areas identified as requiring improvement were communicated widely to all staff members. However, not all staff had received role specific training on safeguarding adults and children. There were sufficient numbers of staff on duty to keep patients safe.

Are services effective?

Good

The practice is rated as good for effective. We found that national data showed the patient outcomes were at or above the average for the locality. Patients' needs were assessed and care was planned and delivered in line with current guidance. Staff were able to receive training appropriate to their roles and further training needs were identified and planned for through the appraisal system. Patients who had complex needs, such as those at the end of life, were discussed at multidisciplinary meetings.

Are services caring?

Good

The practice is rated as good for caring. We found that patients were treated with compassion and respect and their privacy was maintained. Patients said they were involved in care and treatment decisions. The practice provided information in accessible formats to assist patients in understanding the care and treatment options available to them.

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 engaged with the NHS Local Area Team and clinical commissioning group to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as outstanding for well-led. The practice had a clear vision and strategy to deliver this and staff were clear about the vision and their responsibilities in relation to this. The practice had a number of policies and procedures to govern activity and regular

Summary of findings

governance meetings had taken place, which included systems to monitor and improve quality and identify risk. The practice proactively sought feedback from its patient participation group and staff and patients and this had been acted upon.	

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
The practice is rated as good for the care of older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of services, for example in end of life care. Home visits were available for older people if needed.

Good

People with long term conditions
The practice is rated as good for the population group of people with long term conditions. All these patients had a structured annual review to check their health and medication needs were being met. For those patients with the most complex needs the GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care. Nurse led clinics were available to support patients with managing their conditions.

Good

Families, children and young people
The practice is rated as good for the population group of families, children and young people. Children and young people were treated in an age appropriate way and recognised as individuals. The practice operated from 8am to 8pm on weekdays which enabled access for those with family commitments or school age children. Childhood vaccinations were offered in line with national guidance.

Good

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

Good

People whose circumstances may make them vulnerable
The practice is rated as good for the population group of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances such as those with learning disabilities. The practice had sign-posted vulnerable patients to various support groups and voluntary

Good

Summary of findings

organisations. Staff knew how to recognise signs of abuse in vulnerable adults and were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies including outside opening times.

People experiencing poor mental health (including people with dementia)

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). There was a system to highlight vulnerable patients on the practice's electronic records. This included information that informed staff of any relevant issues when patients attended appointments.

Good

Summary of findings

What people who use the service say

Patients completed Care Quality Commission comment cards providing us with feedback on the practice. We received 32 completed cards and the all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive and related to seeing their own GP on same day appointments, but overall they were satisfied with the service provided. Patients told us during our inspection that they were satisfied with the service provided.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 419 patients undertaken by the practice's patient participation group. The results from the practice's own satisfaction survey showed that 90.5% of patients were fairly or very satisfied with service provision.

The evidence from the national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was rated as fairly good or very good overall by 92.5% of patients which is significantly higher than the national average of 85.8%. The practice was also 92%, better than average, for its satisfaction scores on consultations with doctors. The percentage for satisfaction for consultations with nurses was 85% which was in line with the national average. 92% of practice respondents saying the GP was good at listening to them.

Areas for improvement

Action the service SHOULD take to improve

The practice should ensure that all staff has relevant safeguarding training for adults as well as children appropriate to their role.

Dr K. Davidson & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a practice manager.

Background to Dr K. Davidson & Partners

The practice provides services to approximately 25000 patients. Services are provided from Waterside Health Centre, Beaulieu Road, Hythe, Hampshire. SO45 5WX and Blackfield Health Centre, Hampton Lane, Blackfield, Hampshire. SO45 1XA. We visited the Waterside Health Centre for our inspection.

The practice has 18 GPs, eleven of whom are male and the remainder are female. The GPs work between two and eight sessions a week. There are ten practice nurses and three health care assistants, who work a mix of full time and part time hours. These staff are supported by a management team of five people whose roles include a business manager, an operations manager and a finance manager. Also there are designated administrators and reception staff. The practice provides training for GP registrars and medical students.

The practice has opted out of providing out-of-hours services. These are provided by another service.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 November 2014. During our visit we spoke with a range of staff which included GPs, the practice manager, the operations manager, members of the nursing team and administration staff. We spoke with seven patients who used the service. We reviewed 32 comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

Detailed findings

- 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)

The practice population for the age range of 0 to 54 years is similar to the England average. Other age groups, 59 to 85 years and over are slightly above the England average. The percentage of male to female patients is approximately 50%.

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a patient was incorrectly prescribed medicine they were allergic to. The practice checked that the patient had not taken the medicine and rectified the mistake as soon as they were aware of the concern.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred; we reviewed the previous year's record. A time to discuss significant events was seen on the practice weekly meeting agenda, along with time for complaints, compliments and safeguarding concerns. The practice was ISO 9001 accredited for systems and processes in place for the running of the practice. (ISO 9001 is a quality management system that is externally audited and is used to demonstrate control of records, internal audits, control of non-conforming service, corrective and preventative action). These systems were used to ensure significant events were reviewed; action taken when needed and included root cause analysis to identify any trends. For example, we saw there had been a significant incident when one patient was given a flu vaccination twice, due to a failing in recording processes. Action was taken to make sure this did not occur again

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. GPs told us that specific significant events were reported to the local clinical commissioning group (CCG) but this did not follow a protocol and was dependent on professional judgement. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt able to do this.

Relevant national patient safety alerts were disseminated by the operation manager to practice staff. Staff we spoke with were able to give examples of recent alerts relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. However, improvements were needed to ensure all relevant staff had role specific training. Practice training records showed that six out of seventeen GPs and Nurses had not received safeguarding training for children in the past year and that none of the staff had received specific training on safeguarding adults.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children and were able to describe what actions they would take if they suspected abuse had occurred. We noted from practice meeting minutes that safeguarding concerns were a regular agenda item and discussions were held with other professionals when necessary to safeguard vulnerable patients. The practice had a designated training coordinator who was in the process of reviewing all staff's training needs. They were aware of the need to provide safeguarding training and were identifying training providers for this area.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information that informed staff of any relevant issues when patients attended appointments; for example patients who had communication needs and patients with mental health needs.

Patient's individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system to which all patients records had recently been transferred. This collated all communications about the patient including scanned copies of communications from hospitals. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Good

Are services safe?

A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff, including health care assistants. Nurses understood their responsibilities when acting as chaperones including where to stand to be able to observe the examination. (A chaperone is a person who accompanies another person to protect them from inappropriate interactions)

The practice had a risk register in place to monitor unplanned admissions to accident and emergency (A & E). We found that there was a lower number of unplanned admissions via A &E than the national average.

Medicines Management

Medicines stored in the treatment rooms and medicine refrigerators were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was followed by the practice staff, and the action to take in the event of a potential failure was described.

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

National data showed that the practice prescribed less than the average non-steroidal anti-inflammatory medicines such as those used for pain relief. The practice carried out reviews of prescribing to ensure they were in line with national guidance. When needed medicines were changed after consulting the patient concerned.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. Nurses we spoke with confirmed they had received appropriate training and followed the guidance for administering vaccinations.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the codes for the locks were only known by authorised members of staff. There were arrangements in place for the destruction of controlled drugs, which included returning them to a pharmacist or use of destruction kits. There were a limited number of controlled drugs held by the practice.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Curtains used for privacy were dated and changed when required or when soiled. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice was in the process of upgrading all patient waiting and consultation areas to enable them to be effectively cleaned. We saw one consulting room that had been refurbished and noted it was visibly clean and able to be maintained.

The clinical commissioning Group (CCG) carried out an infection control audit in May 2014. The CCG had identified 20 areas for improvement. At the time of our inspection all except one area had been actioned in full. The remaining areas being actioned related to staff hand hygiene checks. An ultra violet light detector had been purchased and was in use. (This piece of equipment allows staff to check that their hand washing technique is thorough). We were told all newly recruited staff had been given appropriate training and had been assessed. A programme was also in place to monitor all staff annually however not all staff had received their first assessment.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example,

personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they used these in order to comply with the practice's infection control policy.

We saw supplies of personal protective equipment which was ready for use if needed. The practice had suitable facilities to support patients with possible contagious diseases. Spillage kits for bodily waste were accessible and kept by the reception desk.

Hand hygiene techniques signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. There were contracts in place for disposal of clinical waste and we saw bins had different colour bin bags in them to segregate the waste.

The practice had a policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing & Recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. All staff had a criminal record check carried out when they started employment as detailed in the practice's policy.

Staffing levels and the skill mix needed to meet patients' needs was planned by the operations manager. We saw the operations manager had three month forward planning for GPs, to identify when annual leave was due and ensure sufficient cover was available. The practice manager said that the practice used two regular locum GPs, to make sure patients experienced continuity of care.

All administration staff and nursing staff said that they were able to cover when there was sickness or annual leave. The duty rotas showed that up to three administration staff could be absent without affecting the service provided. A practice nurse said that they covered staff shifts if a member of the nursing team was sick and their routine work was carried out from both surgeries to ensure they were familiar with the layout of the buildings. The practice nurse told us that they avoided the use of bank nurses when possible, but there were two nurses that were used on occasion who were well known to the practice and familiar with protocols. The practice had overarching management systems and protocols which covered both sites.

Staffing numbers reviews were carried out by the management teams at their meetings. Minutes we looked at confirmed this. The practice had carried out a recent review of administrators and management skill mix and had developed new job descriptions. This review identified that there needed to be a member of staff responsible for overseeing training needs of all staff, this had been put into place three weeks prior to our inspection.

Monitoring Safety & Responding to Risk

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

Identified risks were included on a risk log. Each risk was assessed, rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, there was risk register in place for those at risk of hospital admissions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received

Good

Are services safe?

training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We saw the medicines in the grab bag for GPs to take on home visits were package in plain boxes with a simple label of the name of the medicine contained within the box.

The practice had comprehensive plans and procedures in place for managing the service in the event of an emergency. We saw there was guidance on pandemic and events that could stop the service, such as power failure and adverse weather. The documents also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact in the event of failure of the heating system.

A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice used a software system which had templates based on best practice produced by organisations such as the National Institute for Clinical Excellence (NICE).

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Health and Care Excellence and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The review of the clinical meeting minutes confirmed this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were on appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital which required patients to be reviewed within two weeks by their GP according to need.

National data showed the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancers within two weeks and processes were in place to ensure these were actioned promptly. There was a 'hot desk' which dealt with these referrals and other areas such as, warfarin results, routine referrals and home visits. Staff we spoke with confirmed this. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practise were shared with all GPs and nursing staff.

Management, monitoring and improving outcomes for people

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included support for patients diagnosed with cancer and a comparison of referral rates to secondary care by GPs. We found that records showed that the audit cycle was complete with actions taken and reviews occurring to monitor any improvements. GPs said that other clinical audits were carried out based on the Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for how well they care for their patients. The results are published annually). There were processes in place to monitor the practice performance in relation to these. The practice achieved a percentage of 97.68% for QOF in the year 2012/13 which is higher than the national average. The practice met all the minimum standards for QOF in diabetes/asthma/ chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement and the expectations that they would be responsible for specific areas to audit.

Good

Are services effective?

(for example, treatment is effective)

Staff regularly 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 the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP went to prescribe medicines. GPs said that following the receipt of an alert they had reviewed the use of the medicine in question and where they continued to prescribe it outlined the reason why they decided this was necessary. The showed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a 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).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example travel vaccinations and infection control. The practice was a training practice for doctors who were in training to be qualified as GPs and undergraduate medical students. They had a nominated GP trainer and were given support to complete their training, such as, access to a senior GP throughout the day for support.

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, long term condition management for patients with chronic obstructive pulmonary disease (COPD, a breathing difficulty) and cervical cytology. Those with extended roles were also able to demonstrate they had appropriate training to fulfil these roles. One practice nurse told us that they were responsible for assessing whether a patient's breathing difficulties were reversible (spirometry), by carrying out a test which involved administering a nebuliser to ascertain if symptoms were relieved. They said this had been done routinely at each appointment, but found it was not always necessary. The practice nurse had discussed this with the GPs who agreed that nursing staff could carry out spirometry. This had result in more effective and efficient clinics and time saved was used to educate patients on their condition.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, out of hours providers were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

The practice held multidisciplinary team meetings monthly to discuss the complex needs of patents, such as those at the end of life. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record.

Information Sharing

Information from out of hours providers was sent to the practice each morning and reviewed by GPs. If needed review appointments were made to monitor a patient's condition. The practice contacted the out of hours provider if they had concerns about a patient who might need to be seen.

The practice worked collaboratively with other agencies and regularly shared information (special patient notes) to ensure good, timely communication of changes in care and treatment. For example, the practice had a palliative care register and had regular internal as well as multidisciplinary meetings, known as a 'Virtual Ward

Good

Are services effective?

(for example, treatment is effective)

meeting' to discuss patient and their families care and support needs. The practice worked with the palliative care team and local hospice to discuss patients who were receiving end of life care. GPs reported that there was contact with the hospice most week days.

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. This system had finished being put into place the day prior to our inspection. The practice manager said that the transfer over of patient records had been successful and staff had not reported any problems with using the new system.

Consent to care and treatment

Staff were aware of how to obtain patients consent for treatment and care and could describe actions that they would take. However, they had not received any formal training on the Mental Capacity Act 2005, although they could demonstrate the principles, and knew about use of advocates when needed.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity. All GPs and nursing staff demonstrated a clear understanding of Gillick competencies. (Gillick competency is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions)

Young people were able to access the practice and have their confidentiality maintained. GPs told us that there were no age barriers. They would make an assessment based on Gillick competency about whether a patient under the age of 16 years was able to make an informed decision.

Health Promotion & Prevention

The practice had met with the Public Health team from the Local Authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer all new patients registering with the practice a health check. Any health concerns detected were followed-up in a timely manner. We noted a culture amongst the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers. The practice also offered NHS Health Checks to all its patients aged 40-75. Patients who had been offered health checks, but did not take up the offer were contacted by the practice to remind them of this service.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities and all 69 were offered an annual physical health check which was planned for the month of their birthday.

A register was maintained of patients who were admitted to accident and emergency (A & E) and measures were taken to reduce unplanned admissions to A & E, which had resulted in a low number of admissions.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance Last year's performance for all immunisations was similar to the average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 419 patients undertaken by the practice's patient participation group. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was rated as fairly good or very good overall by 92.5% of patients which is significantly higher than the national average of 85.8%. The practice was also 92%, better than average, for its satisfaction scores on consultations with doctors. The percentage for satisfaction for consultations with nurses was 85% which was in line with the national average. 92% of practice respondents saying the GP was good at listening to them. The results from the practice's own satisfaction survey showed that 90.5% of patients were fairly or very satisfied with service provision.

Patients completed CQC comment cards providing us with feedback on the practice. We received 32 completed cards and the all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect.

We also spoke with seven patients on the day of our inspection. Five of the patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. The other two patients had raised concerns with the practice about the care and treatment they had received, which were currently being investigated.

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

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Staff were observed being kind and courteous to patients. There was a red line on the flooring in reception for patients to wait behind until they were called to the desk, this provided privacy and protected confidentiality. There was also a quiet space at the reception desk for patients' confidentiality.

Both male and female patients were able to have a chaperone with them if they chose. When needed a larger clinical room was used for intimate examinations, so the patient did not feel enclosed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Staff told us about some incidents where they had been concerned over patient attitude and these were dealt with effectively by the management team.

The practice was aware of vulnerable groups in the community they served. These included travelling communities who had settled and single parent families. Staff members demonstrated an awareness of their specific needs which could affect the health of vulnerable patients. For example, social issues which could prevent them from attending for health checks when needed.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 85% of practice respondents said the GP involved them in care decision; this was slightly above the national average.

Patients said they were involved in their care planning and given suitable information about treatment options. They reported that GPs and nurses took time to explain their treatment so that they had a good understanding of what was involved. Patient feedback on the comment cards we received was also positive and aligned with these views. The practice had provided dementia awareness training for all clinical staff and all patients over the age of 75 had a named GP.

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

Good

Are services caring?

also saw that there was a hearing induction loop in place for deaf patients. (A hearing loop allows patients who wear hearing aids to minimise background noise when speaking to other people). We saw notices in the reception areas informing patents this service was available.

Care plans were in place for patients with long term conditions, such as asthma, however these were pre-printed and not fully personalised. The practice could consider developing their care plans to show that patients have been involved in care planning and the plans meet individual needs.

Patients who were receiving end of life or palliative care were discussed at monthly meetings, which involved other health professionals such as district nurses. Each patient had a personalised plan of care which was made available to the out of hours provider and ambulance services.

We found that the practice website and booklet had information on support groups and health checks that patients were able to access.

Patient/carer support to cope emotionally with care and treatment

The practice survey showed that 67.5% of respondents usually saw their own GP which helped to provide continuity of care and support.

Notices in the patient waiting room, on the TV screen and patient website signposted people to a number of support groups and organisations. The practice was aware of who had caring responsibilities, and this was flagged up on the system. One GP said that patients were not routinely asked about this, but there was a form available for patients to complete, we saw an example of this form.

The practice website showed that one of the GPs had an interest in holistic care, which included palliative care. Practice meeting minutes documented that families of patients who had died were contacted by their usual GP to offer support.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The practice used risk tools, which helped GPs detect and prevent unwanted outcomes for patients. This helped to profile patients by allocating a risk score dependent on the complexity of their disease type or multiple comorbidities.

The practice had implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the patient participation group (PPG). The most recent was the successful bid to manage and provide phlebotomy services, which had been highlighted by the PPG as an area for improvement.

The practice told us they were involved with the local clinical commissioning group to plan and implement services for patients in the area. They met regularly with other practices, as part of a separate limited company of 17 GP practices to bid for contracts to provide local services to patients. . For example the identified need for a new phlebotomy service was secured and is due to commence in January 2015 for the benefit of patients of 17 practices in the area. The team would consist of a full time phlebotomist, two health care assistants and some reception staff were being trained to take blood.

Longer appointments were available for patients who needed them and for patients with long term conditions. This also included appointments with the patients usual GP. If needed home visits were arranged.

Tackling inequity and promote equality

The practice had recognised the needs of different groups in the planning of its services. There was a system in place for flagging whether a patient was at risk of abuse or was a carer. GP services were provided to local care homes on an individual patient basis. Care homes included one for patients with learning disabilities. The practice had access to online and telephone translation services however the lead GP said that Polish speaking patients who worked in the area were often accompanied by a work colleague to interpret for them.

The practice was situated in purpose built premises which met access requirements for patients with disabilities. All consulting rooms were on the ground floor. There was a door bell for patients with reduced mobility to alert staff to open the main practice door for them. The practice had a hearing induction loop in place and there were toilet facilities for patients with disabilities and parents with children.

Access to the service

Appointments were available from 8am to 8pm Monday to Thursday and 8am to 6.30pm on Fridays at both the Waterside and Blackfield Health Centres. Pre bookable late appointments were available on Monday, Tuesday, Wednesday and Thursday evening at Waterside health centre, and on Tuesday and Thursday evening at Blackfield Health Centre. In addition a late evening nurse led clinic was available to 7.30pm on Tuesday and Thursday evenings at the Waterside Health Centre. The practice had opted out of out of hours care, which was provided by another service.

Comprehensive information was available to patients about appointments on the practice website and in the practice booklet. The practice booklet set out information in the form of a table with a photograph of each GP and the days they were available for appointments and which health centre they would be based in. Information within the practice booklet and on their website explained how patients could make routine, home visits and urgent appointments. The practice ran a named GP list, which enabled patients to receive continuity of care when attending routine appointments. Routine appointments were available up to two weeks in advance. An urgent care clinic in operated daily. Calls into the practice for urgent appointments were triaged and arrangements made for a telephone consultation or an appointment with a GP or practice nurse for the same day, dependant on the patients concern.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another doctor if there was a wait to see the GP 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

A weekly audit of pre-bookable appointments was carried out to determine whether there were sufficient clinical hours available for GPs to see patients. If needed extra appointments were put into place and covered by GPs or locums.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the website, in the practice booklet and displayed in the waiting area. Two patients of the seven we spoke with were not aware of the formal complaint system, as they had not needed to raise any issues. They said if they had a concern they would speak with a GP or the practice manager. Two other patients we spoke with were in the process of having their concerns investigated. They both said that they were being kept informed of the progress and when the investigation would be concluded.

We looked at 13 complaints received in the last twelve months and found all were responded to and fully investigated within the timeframes published by the practice. Any actions which were needed to improve the service provision were put into place and reviewed to ensure they were effective. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified, however lessons learnt from individual complaints had been acted upon.

Are services well-led?

Good

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

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were incorporated in the day to day running of the practice. The practice vision and values included engaging patients in managing their health and shaping the service, as well as working in a culture of equality and continuous improvement. This was reflected in the aims and objectives of the patient participation group (PPG) and how staff were supported. Staff told us that how the practice was developing was shared with them by the management. There were also opportunities to discuss patient care and areas for improvement. Comments from some members of staff indicated that they considered Dr Davidson and Partners to be the best practice they had worked in. Staff were clear on their roles and responsibilities and how this contributed to a positive patient experience. Staff said that the practice was supportive and accommodating of individual circumstances which made them feel valued.

The lead GP was due to retire in 2015 and arrangements were already in place to ensure a smooth handover. The practice manager had been in post for a year and had developed the management systems in the practice to make sure staff had clear roles and responsibilities, in collaboration with the registered manager.

Governance Arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. The practice was accredited for ISO 9001, (this is a system for quality management which is accredited on a three yearly basis and six monthly checks are made of the system) which informed the practice manager when policies and procedures required reviewing to ensure they were up to date. For example, the practice found that a paper copy of the locum doctors handbook was out of date, so arrangements were made to make this policy accessible on the computer system and remove the paper based folder, to ensure information was up to date and accurate.

The practice held monthly governance meetings. We looked at a sample of minutes and found that performance, quality and risks had been discussed. We noted each GP had an educational annual appraisal and six monthly protected learning sessions. However, there were no formal processes for gathering learning needs or topic based clinical meetings.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at meetings and action plans were produced to maintain or improve outcomes. The practice told us they were trialling pre-coding for QOF. This entailed coding information received from other providers prior to the GP seeing the patient, for example, discharge summaries received from hospitals.

The practice had completed a number of clinical audits, these included comparison of referral rates to secondary care by GPs and improving the quality of care for patients with cancer in the primary care setting.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as prescribing errors and breaches of referral times. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, there had been a delay for one patient in being referred to a secondary care provider and systems were put into place to ensure there was better monitoring to prevent reoccurrence.

Leadership, openness and transparency

We were shown a clear leadership structure which had clear detail of the role of each person. There was a management team which consisted of the practice manager and GP leads that had responsibility for specific areas, for example, operations or finance. Also in the team was an operations manager, a finance manager, a nurse manager and an information and technology manager. This team operated across both sites and were responsible for managing a particular sub team, for example the nursing team. The operations manager was supported in their role by a training officer.

The practice had a lead nurse for infection control and GP partners were responsible for areas of practice such as safeguarding and long term conditions. Staff said they were

Are services well-led?

Good

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

all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns. Information was mainly cascaded to members of staff via email; staff said that their line manager's checked that they had read the information and made changes to their practice if required, through meetings and the appraisal system.

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

We were shown the staff handbook that was available to all staff, this included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and spoke with two members of the patient participation group (PPG). The PPG met monthly and had representatives from both sites. There was a committee of 16 who met monthly and 120 virtual members who were contacted via email. The practice booklet clearly stated that all patients were members of the group. The two members said that they had assisted the practice in becoming more patient focussed by acting as the patient voice. There was a link from the practice website to the PPG's. We were shown the draft of the terms of reference for the PPG that the aims and objectives of the group were patient focussed.

The PPG had links with the clinical commissioning group, the audiology service and met with them at least twice a year to discuss patient needs and were representative of the Family and Friends test. The two members said that as a result of a survey the appointments system was refined to better meet the needs of patients and reception staff now answered the phone and gave the caller their name. The group was also working with a local carers group to offer a drop in service at the practice to provide support.

The PPG group had carried out annual surveys and were in the process of updating their website with current information and what had been achieved since the last survey. The PPG group considered that they were a 'critical friend' of the practice and GPs listened and responded to what they had to say. They considered they had a constructive and positive relationship with the practice.

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

Management lead through learning & improvement

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

The practice was a GP training practice and provided placements for undergraduate medical students as well as GP trainees. There was a designated trainer, who maintained links with the medical Deanery to support trainees.

The practice had completed reviews of significant events and other incidents and shared with staff via meetings to ensure the practice improved outcomes for patients.