# The Wilson Practice

## Quality Report

The Wilson Practice, Alton Health Centre, Anstey Road, Alton, Hampshire
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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? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Good |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at The Wilson Practice on 5 February 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the populations groups.

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

- The practice leads the local integrated care team "Rowan", which covers approximately 30,000 patients and the four local practices. They were working closely with the whole team to look at new ways of providing healthcare to their population.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

# Summary of findings

The provider must:

Ensure staff received training to carry out their role, in particular infection control training and chaperone training.

**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?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Staff received training to enable them to carry out their Duties. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

**Are services caring?**

**Good**

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

**Are services responsive to people's needs?**

**Good**

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

# Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We noted learning from complaints was shared with staff and other stakeholders.

**Are services well-led?**

Good

The practice is rated as good for being well-led. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on. The patient participation group was active. Staff had received inductions, annual appraisals and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

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

**Older people**

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of older patients. This included personal lists and practice based or domiciliary clinics, for those over 75 years of age, consisting of half hour appointments. Regular meetings were held with integrated care and multi-disciplinary care teams. Patients receiving end of life care and support also had care plans which were shared using the special notes system with other out of hours providers. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. Computer templates and protocols were in place to coordinate appropriate effective care. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Annual review recalls were sent for all patients with long term conditions. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check whether their health and medication needs were still being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

Good

The practice is rated as good for the care of families, children and young people. The practice encouraged families to have the same named usual GP. Regular meetings were held with other health professionals, such as health visitors, to discuss vulnerable patients. For example those who were pregnant and patients at risk of harm. Systems were in place to code patients' records to identify children at risk of harm. All staff had received training in safeguarding adults and children, and this had also covered domestic violence and staff could demonstrate what action they would take if needed. The practice had a dedicated immunisations clinic and practice nurses were trained to monitor children with asthma. If young people or children did not attend for appointments there were protocols in

# Summary of findings

place to contact the family and offer an alternative date and time. Longer appointments were offered for six week baby checks. The practice had contact with local schools and colleges and community nurses assigned to work at those places.

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

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of this group. NHS health checks were offered to all patients under the public health scheme. We found that travel clinics were available in the late evening to allow working patients to attend.

**People whose circumstances may make them vulnerable**

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were advised of how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice maintained personal lists to provide continuity of care. Follow ups for patients with mental health conditions who had had a hospital admission were available at the practice or by a telephone call. The practice carried out virtual weekly ward rounds and worked closely with Older Patients Mental Health services to provide coordinated care. Patients who were subject to deprivation of liberty safeguards had care plans in place. The practice proactively used a toolkit to diagnose dementia to identify patients early and put appropriate support and treatment in place.

# Summary of findings

## What people who use the service say

Results from the national patient survey showed that 93.4% of patients would recommend the practice to others. We spoke with eight patients who were all positive about their experience of using the practice. They said they were treated with respect and care and treatment was explained to them. We received 20 comment cards and all responses were positive and stated that they were treated with respect and had sufficient information to make a decision. They considered the practice to be clean and tidy and were able to raise concerns if needed.

National patient survey results showed that the practice was performing either in line or higher than the national average in areas for example, 78% of respondents said they were involved in decision making (national average 81%); 94% of respondents said they were treated with care and concern (national average 85%); and44% of respondents said they were able to speak with or see the GP they preferred (national average 37%).

## Areas for improvement

**Action the service MUST take to improve**

Ensure staff receive training to carry out their role, in particular infection control and chaperone training.

# The Wilson Practice

**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 practice manager specialist advisor.

## Background to The Wilson Practice

The Wilson Practice is situated in Alton Health Centre, Anstey Road, Alton, Hampshire. GU34 2QX. There are approximately 14,000 patients registered with the practice. The catchment area covers Alton and the surrounding villages. The practice has a spread across all age groups with slightly higher numbers of patients who are in the 65 to 69 years age group. The practice area is one of the least deprived areas of England.

The practice holds a GMS contract and has six female GPs and four male GPs. Six of the GPs are partners and there is one fixed share partner, two salaried GPs and a registrar who is a doctor who is training to be a GP. The GP team is supported by a business director, a practice manager, nine receptionists, three secretaries, five administration staff, six nurses and three healthcare assistants and a person responsible for minor repairs and general duties.

The practice has opted out of providing out of hours services to their own patients; these are provided by Hants Doc, via 111.

## Why we carried out this inspection

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

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

## How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew, including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 5 February 2015 at The Wilson Practice. During our visit we spoke with a range of staff which included GPs, nurses, the practice manager and reception staff. We spoke with patients who used the service. We reviewed 20 comment cards where patients and members of the public shared their views and experiences of the service.

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

# Detailed findings

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

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

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

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

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People whose circumstances may make them vulnerable
- People experiencing poor mental health (including people with dementia)

Requires improvement

# Are services safe?

## Our findings

### Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, an audit identified that there had been delays in making referrals to secondary care services, such as hospitals. Actions taken included supporting staff and further checks on their referrals to ensure they had been sent.

We reviewed safety records, 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 show evidence of 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. There was a specific proforma for staff to complete when a significant event occurred. These were discussed at meetings which involved relevant members of staff. Staff said that significant events were taken seriously and there was an open, no blame culture to enable them to report events and discuss where improvements could be made. We reviewed the significant event log for the previous 12 months and found that actions had been taken when needed. For example, the practice had identified an occasion where there was a breach of patient confidentiality, when information was given to a patient with the same name as another. Action had been taken to prevent this occurring again and this involved tighter checks on the identity of the patient making the request.

### Reliable safety systems and processes including safeguarding

The practice had systems in place to protect patients from harm. These included policies and procedures related to child and adult safeguarding. Both policies had been reviewed and contained contact details of relevant authorities who needed to be informed of any safeguarding concerns. The policies were accessible to all staff via the practice's intranet.

National patient safety alerts were disseminated by the practice manager to relevant staff to act on. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at meetings and minuted to ensure all staff were aware of any that were relevant to the practice and where they needed to take action. Alerts were usually received via email and circulated to the appropriate staff groups for action. For example, when a medicine alert was received, staff were required to initial a paper copy of the alert to indicate they had read it; the initialled copy was then scanned into the computer system and saved. Urgent alerts were scanned into the system and actioned immediately when these were received.

Training records showed that all practice staff had completed training on safeguarding adults and children at a level appropriate to their role. The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three for safeguarding children, and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with knew who these leads were and who they should speak with in the practice if they had a safeguarding concern. Examples given of potential safeguarding concerns that staff had identified included inappropriate behaviours of a carer who handled a patient roughly and a spouse being verbally aggressive to a patient in the reception area.

A chaperone policy was in place and there was information in the waiting room about this and on notices displayed in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure.) Chaperones were clinical staff such as nurses or health care assistants. These members of staff had a criminal records check carried out via the Disclosure and Barring Service (DBS). Some receptionists carried out chaperone duties and had received training to do this. Staff reported that although they had received training this did not include what they should expect from an examination and a member of staff said they had been told to sit at the GPs desk, rather than be at the patient's side. These members of staff had not had a DBS check, but there was a risk assessment in place detailing what they were able to do when chaperoning patients. GPs said that female patients always had a chaperone and male patients were offered the option of having a chaperone.

Requires improvement

# Are services safe?

The practice had a whistleblowing policy in place for staff to use if they considered it was necessary. Staff said that if they had any concerns they would not hesitate to speak with the practice manager or a GP Partner.

### Medicines management

There were systems in place for managing medicines within the practice. Suitable lockable cupboards were provided for medicines to be stored securely. There was a designated refrigerator for storing medicines which needed to be kept at a low temperature. Records we looked at showed the refrigerators were operating within safe limits. There were clear instructions detailing what actions staff should take if there was an interruption in the cold chain of vaccines. Patients group directions and patient specific directions were in place for vaccinations and other injections.

GPs said they used a specific emergency bag for home visits, the contents, which included medicines, were checked monthly to ensure they were suitable for use and within their expiry date. The emergency bag was kept in a locked safe when not in use.

Patients were able to request repeat prescriptions electronically and in writing. There were suitable processes in place for ensuring that these prescriptions were only produced within set timescales. The practice had experienced some issues with incorrect medicines being dispensed by pharmacies. They had collated a log of incidents and were working with the pharmacies concerned to rectify errors. Some of the complaints received by the practice related to errors with prescriptions, these were thoroughly investigated and resolved to the patient's satisfaction whenever possible. For example, a patient being advised to take a higher dose of medicine than needed.

The practice met monthly with a prescribing pharmacist to review and monitor medicines. The meeting covered medicines prescribed and whether there were more cost effective treatments available that would be suitable for use. When needed patients' medicines would be reviewed and changes made with their consent.

### Cleanliness and infection control

The practice had a designated infection control lead and policies and procedures were in place for staff to adhere to in order to minimise the risk of cross infection. Liquid soap, paper towels and hand gel were available in the practice in areas such as consulting and treatment rooms. Staff said they had sufficient personal protective equipment, such as gloves and aprons to use. We observed that treatment and consulting rooms had sharps bins for used needles and syringes. The landlord (NHS Property Services) had a clinical waste contract in place to dispose of any contaminated items safely.

We observed that the premises were visibly clean and tidy. There were cleaning schedules in place and cleaning records were kept by external contractors who cleaned the premises. The practice did not carry out audits of the environment to ensure they were clean. These were carried out by the landlord and shared with the practice, however, records were not available on the day of inspection to confirm this. Staff said that if there were any concerns with the cleanliness of the practice then these were discussed with the cleaning contractors. However, this was not routinely documented . Patients who completed comment cards had no concerns about cleanliness or infection control.

The practice had an identified infection control nurse lead who liaised with the clinical commissioning group's infection control lead on best practice. We saw an audit of infection control had been carried out in December 2014, which identified concerns related to privacy curtains in consulting rooms only being changed annually, instead of at least every six months, or more often if needed, in line with best practice. The practice had not indicated how they would ensure that curtains were appropriately cleaned and remain suitable for use. Training records provided by the practice prior to the inspection showed that seven of the nine nursing and healthcare staff had completed training on infection control procedures in 2014. Another concern identified by the audit related to records of decontaminated equipment not being kept this was implemented at the time of the inspection.

The practice had a purpose built minor injuries theatre and used single use equipment when carrying out procedures. The minor injuries clinic was available for use by patients of other practices in the Alton area through the contract the practice had. Appropriate systems were in place to ensure all equipment was clean and suitable for use. The clinical commissioning group and GP practices had worked together to centralise some areas of treatment to make best use of funding and resources available.

Requires improvement

# Are services safe?

### Equipment

Staff we spoke with told us they had 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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure monitors. Calibration is where the equipment is checked to ensure it provides accurate measurements.

### Staffing and recruitment

The practice had systems in place for recruiting new staff, which included an up to date recruitment policy. We looked at a total of seven staff recruitment files which included those for GPs, nurses and administration staff. We found that all had evidence of satisfactory conduct in previous employment, a full employment history and, in five files, evidence of criminal records checks carried out via the Disclosure and Barring Service (DBS). The other two files related to salaried GPs who had been employed prior to the practice being registered with the Care Quality Commission. The recruitment process was carried out in line with their policy and included copies of interview notes, which is deemed to be best practice.

The practice manager said they carried out checks on the GP performers' list annually, to ensure GPs were registered to work. The performers' list has details of whether a DBS check has been carried out. However, this check by the practice manager had not been recorded. Nursing staff had their registration with the Nursing and Midwifery Council checked on an annual basis and there was evidence of this in their files. We noted that reception staff who carried out chaperone duties had not had a DBS check, but there was a risk assessment in place to explain the procedures they should follow if chaperoning a patient.

The practice manager said that an analysis was undertaken of telephone calls received by the practice. Results of the analysis were used to ensure that there were sufficient numbers of reception staff on duty at peak times. The nursing skill mix and numbers were determined by clinic times. There was always a duty nurse available or staff who worked in the minor injuries clinic to cover an increased demand.

When locums GPs were used by the practice they were given a comprehensive induction booklet. We found this booklet included relevant contact details of local hospitals; details of staff who worked in the practice and their roles; access arrangements to the building; and a profile of the demographics of the practice.

The practice used an electronic prescribing system and was able to monitor usage to ensure there were sufficient staff to process requests. Contingency plans were in place in case a GP was ill or unavailable whereby the duty GP would cover the appointments alongside other GPs working. GP staffing levels were reviewed on a quarterly basis based on appointments requests and telephone calls. Adjustments were made in response to demand. Minutes of meetings confirmed this.

### 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 environment to ensure it was hazard free, medicines management, staffing, dealing with emergencies and equipment, for example portable appliance testing. There was a health and safety policy in place and all staff we spoke with were aware of the policy and stated that risk assessment was part of the practice ethos.

The practice ran a minor injuries walk in clinic which was open from 8am until 6.30pm where patients could access treatment from a nurse. Patients did not have to be registered with the practice to use it.

### Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records and staff confirmed that they had received basic life support training. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm.). Staff were able to tell us where this equipment was located and how to use it, records confirmed that the equipment was checked regularly.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal

Requires improvement

# Are services safe?

heart rhythms and low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

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.

The practice used a software system that had assessment and treatment templates based on best practice guidance. The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from specialist clinical guidance websites. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

In response to areas of concern that the practice had identified, audits of referrals to hospitals had been carried out for all GPs, to ensure they were achieved in a timely manner and were relevant and appropriate. This work had commenced about six months prior to our inspection and was on going, the practice reported that there had been an improvement in referrals being made in a timely manner, which had previously caused distress to some patients.

### Management, monitoring and improving outcomes for people

The practice had systems in place for the management, monitoring and improving outcomes for patients. For example, all patients who were on the 2% admissions avoidance list were reviewed every three months, to ensure their care plans were still applicable. The computer system would flag up when a review was due, to ensure it was carried out. Patients who had complex treatment needs or had a care plan in place were offered longer appointments to enable the GP to discuss their condition and offer advice on self-management.

Information from the quality and outcomes framework (QOF), a national performance measurement tool, showed that the practice achieved 97.9% in its QOF results, which was slightly higher than the practice average across England. Specific areas where the practice achieved above the national average for QOF areas included: patients who were aged 65 years and over who had received the flu vaccine; and patients with diabetes who had a received a foot examination in the preceding 12 months.

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included ones related to QOF outcomes, for example antibiotic prescribing and usage. The second cycle of this audit showed an improvement in adherence to relevant guidance. All GPs have to undertake an audit as part of their appraisal process. Other examples of completed clinical audits we saw included checks being made on patients who were receiving warfarin ( a blood thinning medicine, used to minimise the risk of blood clots) to ensure that they were on the correct dose and this was controlled effectively.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by their usual GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being followed.

Doctors in the practice undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used them in their learning.

### Effective staffing

The practice had suitable systems to ensure staff were trained to carry out their roles. All staff had received an annual appraisal and training and development plans were put into place following the appraisal. The practice used a 360° appraisal for all staff to provide a full assessment of their performance. Job descriptions for each role were also reviewed during the appraisal and changes made and agreed as staff roles developed. If there were issues with poor staff performance, this was managed using a supportive approach, such as refresher training or mentoring. There was a formal disciplinary process in place should it be required.

New employees were subject to three and six monthly reviews, which allowed learning needs to be identified early on and planned for. Staff we spoke with confirmed that

Good

# Are services effective?

## (for example, treatment is effective)

they received specific training appropriate to their role and were fully involved in the process. Further training had been provided to develop staff in their roles. For example, all three healthcare assistants employed were trained to undertake phlebotomy, carry out ECGs and treat minor injuries.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers' list with NHS England).

GPs met each morning and used this time to discuss patients they had seen or to share information. Other members of the staff team would also join them to discuss patient care.

Suitable arrangements were in place to ensure there were sufficient staff on duty. Nursing staff were able to cover more than one type of clinic and the minor injuries clinic when needed. There was a duty GP system in place and when required other GPs would see patients for appointments if there was sickness or a busy period.

Nurse led clinics were in place for long term conditions, and each disease domain had a named GP as clinical lead. The practice intranet had resources available for staff to use to provide effective treatment in line with best practice.

### Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received.

The out of hours service (OOH) was able to access summary care records held by the practice. Summary care records consist of important details about a patient, such as known medicine allergies, brief details of their past medical history and whether they had a current care plan in place. The practice sent information to the OOH service via fax and information received from the OOH service was received via email.

Blood test results were usually dealt with by the patient's designated GP. All GPs ran personal lists. If a patient's GP was not available then the result would be passed to the duty GP for action.

Regular meetings were held with other health professionals, such as district nurses and health visitors, to discuss patient needs or safeguarding concerns. Patients who were receiving end of life care were discussed at regular meetings with the community care team and risk assessed according to their condition, to make sure effective treatment was provided. A spreadsheet captured information from these meetings and we found that it was updated weekly to ensure information was accurate.

The practice was able to access X-rays which had been taken in hospital on their computer systems and discuss these with a consultant from the hospital

### Information sharing

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

There was a policy in place on data security and protection. Access to the computer system was restricted according to the role a member of staff carried out. For example, reception staff were not able to access specific details on clinical care and treatment.

Patients who had care plans for their condition, such as end of life care, had an alert on their patient record. Child protection alerts were also placed on patient records. This allowed other staff members to be aware of specific needs or concerns about those patients.

### Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice.

Good

# Are services effective?

## (for example, treatment is effective)

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

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures a specific form was completed.

**Health promotion and prevention**

There was a health promotion notice board situated in the waiting area. We saw this had information on contraception, shingles and alcohol consumption. This notice board was maintained and updated by the patient participation group (PPG).

The practice offered new patient checks when a patient first registered with them. They also offered NHS Health Checks to all its patients aged 40 to 74 years. 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 above average for the clinical commissioning group.

GPs said there were various support services in the area which they were able to refer patients to, or to which patients were able to self-refer. For example, exercise classes, voluntary support organisations and adult education classes.

Members of the PPG assisted with flu clinics and used the opportunity to provide information on keeping well and identifying patients who were also carers. The PPG also organised an annual health fayre aimed at promoting health and wellbeing. They would invite other health and social care organisations and neighbouring GP practices to have stand where patients could visit for information. Stands included 'while you wait' tests for blood pressure, cholesterol and blood sugar, and information on smoking cessation and misuse of drugs. The PPG had facilitated a men only slimming group, which proved to be popular and produced overall positive effects on their health.

Good

# Are services caring?

## Our findings

### Respect, dignity, compassion and empathy

We observed reception staff treating patients with respect when they spoke with them, either on the telephone or face to face. There was information for patients that a room was available for use if they wished to discuss a private matter. Results from the national GP survey showed that 87% of patients described their overall experience of the GP practice as fairly or very good and 93% of respondents stated that the last time they saw a GP they were good or very good at treating them with care and concern. Eighty four percent of respondents stated that nurses were good or very good at treating them with care and concern.

### Care planning and involvement in decisions about care and treatment

All the patients we spoke with and the 20 comment cards completed were complimentary of the staff at the practice and the service received. Patients told us that they felt listened to and involved in the decisions about the care and treatment. Patients were given appropriate information and support regarding their care or treatment.

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

The practice identified all vulnerable groups and offered personal care plans which were updated regularly and included medicines use and wishes of patients at end of life. The practice manager explained that patients were involved in producing their care plans and we saw evidence which confirmed this.

### Patient/carer support to cope emotionally with care and treatment

The practice maintained a list of carers and would place an alert on their records to inform other staff members of the patient's caring responsibilities or whether they were cared for. A member of the patient participation group said that they assisted with flu clinics and used this as an opportunity to identify patients who had carers or were carers. They added that they had worked with another practice in the area to produce a community support directory, which included details of carer and patient support groups such as Arthritis Care, the Alzheimer's Society and Autism Hampshire. GPs said that when a patient died they would phone or visit the next of kin to offer condolences and 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 patients' 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 in the way services were delivered. For example, the practice used a GP toolkit to diagnose dementia and had started to take steps to become a dementia friendly practice, with the involvement of carers. The practice considered that use of personal lists offered continuity of care and promoted quality in mental health care. The practice led the local integrated care team 'Rowan' which covered approximately 30,000 patients and four GP practices. The whole team were looking at ways of providing healthcare to their population, such as intravenous therapy in the community. Intravenous therapy is where medicines such as antibiotics are administered into a vein. The practice had introduced practice based or domiciliary clinics for the over 75s which involved half hour appointments.

The practice had employed a GP, along with three other practices to visit care homes in the area each week to provide care and treatment. This GP also carried out two sessions per week at the practice.

The NHS England Area Team and Clinical Commissioning Group told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements.

The practice regularly engaged with community services that provided support to vulnerable groups, such as homeless patients. They said that patients experiencing mental health conditions did not always receive appropriate medical support from other providers and local hospital as there was a lack of resources available, particularly for young adults and children.

### Tackling inequity and promoting equality

Patients who were on the learning disability register were invited for an annual review and had longer appointment times for this. The practice said there was a settled travelling community in the area and they were flexible with appointments for this group. On occasion appointments would be made for this group of patients and they would not keep them, but present at the practice at a later time. The practice said they were always seen. Twice a year a travelling fair visited the town and the practice provided temporary medical cover for them.

The practice said that patients who were homeless were able to use the practice address as their registered address to receive letters and receive treatment when needed.

The practice had used a translation services when needed. They said that there was a high number of Polish speaking patients and when needed they were given longer appointment times to allow for interpretation.

We saw there was a hearing induction loop in place for deaf patients and the reception desk had a lowered area to allow wheelchair users to speak with reception staff. Reception staff said that if needed they assisted patients to complete paperwork. There were accessible toilet facilities and a baby changing area.

### Access to the service

The practice was open from 8am-6.30pm and morning surgery took place from 8am to 11am; afternoon surgery was from 4pm to 6pm, with some earlier appointments being available. A minor injuries clinic operated Monday to Friday between the hours of 8am and 6.30pm. Patients whether they were registered at the practice or not were able to use this service. The practice had a duty GP system to provide same day appointments, either face to face or on the telephone. Same day appointments were available for those patients who were homeless or had mental health conditions. The practice said they would never turn anyone away who was in need of medical attention.

The practice manager said that they were constantly reviewing appointment availability and worked with the patient participation group to gather the views of patients. Patients were able to book appointments on line, via telephone calls or face to face. Older patients and those who were vulnerable were able to access longer appointment slots. Longer appointments were also available to carry out six week baby checks. Specific clinics were held for conditions or patient groups, such as well women, travel, coronary heart disease and NHS health checks. We found that travel clinics were available in the late evening to allow working patients to attend.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

### Listening and learning from concerns and complaints

The practice has a system in place for handling complaints and concerns. Its complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. Information about how to make a complaint was available on their website and in reception.

When needed the practice would apologise for any shortcomings, and advise the complainant of actions taken as a result of their concern. We noted that if a complainant was not satisfied with the response, information had been provided on other agencies they could take their concerns to, such as the Health Service Ombudsman or local Patient and Liaison Services. The practice manager said that complaints were discussed in meetings and recorded, we were provided with a summary of complaints received which confirmed this. The practice had reviewed complaints and we saw evidence of how learning from complaints took place and the actions undertaken to improve the service.

# Are services well-led?

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

## Our findings

### Vision and strategy

The practice set out their vision at the start of our inspection; they considered the main aim was to have an ethos of practice to provide excellent holistic medical care in an environment where learning was supported. Staff said that they were aware of this vision and agreed with it. They felt involved in achieving and maintaining this vision and considered working on being a productive practice had significantly helped in driving improvement forward. The Productive General Practice programme is designed to help general practice continue to deliver high quality care whilst meeting increasing levels of demand and diverse expectations. It helps practices to put the patient, clinician and practice team at the centre of improvement to create a timely, appropriate and dependable response to patient needs. Implementing the programme engaged all staff in the practice in improving their work processes, making it possible to release time to invest in improving patient outcomes and staff wellbeing.

### Governance arrangements

The practice used the Quality and Outcomes Framework (QOF) to measure their performance. (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, for example diabetes and implementing preventative measures. The results are published annually.) The QOF data for this practice showed it was performing in line or above with national standards. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. The practice had completed a number of clinical audits, for example medicines prescribing. Learning from these audits had taken place when needed and reviewed.

The practice had nominated leads for areas such as safeguarding, complaint handling and infection control. These staff members were responsible for disseminating relevant information to staff teams. The practice manager met on a regular basis with the clinical commissioning group to discuss best practice and health needs in the area.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. The practice had arrangements for identifying, recording and managing risks. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. The practice held regular multidisciplinary meetings as well as meetings for safeguarding avoidance and significant events. We looked at minutes from some of these meetings and found that performance, quality and risks had been discussed.

### Leadership, openness and transparency

Staff said that the partners, GPs and practice manager had an open door policy and they would not hesitate to approach them to discuss concerns. The staff also considered that they were kept informed about the how the practice was run. All staff said that they felt valued and supported. They considered that staff respected each other and worked cohesively as a team, this was aided by multidisciplinary team meetings which were held monthly. A salaried GP said they received minutes of meetings and felt involved in how the practice operated. They added that all staff were open to discussion to improve the patient experience.

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

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said they felt engaged and involved in the practice to improve outcomes for both staff and patients. They said GPs and the practice manager were responsive and listened to their ideas and took action when needed.

The patient participation group (PPG) met monthly and was open for any patients to attend. The member of the PPG we met said that they would organise speakers to give talks at meetings on how health and social care was organised and funded. The person considered that the group was representative of the patient population, for example there was a representative from the local sixth form college. There was an additional virtual group which consisted of a larger number of patients and was more representative of the patient population. Such as, mothers, who may find it difficult to attend meetings. The PPG was involved and consulted on changes to the health services in the area via the clinical commissioning group and the GP practice.

# Are services well-led?

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

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development. The practice was a GP training practice and GP registrars and students attended from Southampton University.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings. Significant event records described the actions taken by the practice in respect of the patient's care and how they shared and required improvements with other providers. The practice also had regular meetings with other GP practices in the Alton area to share learning and best practice; GPs and nurses attended these meetings. The practice had supported some reception staff to train as healthcare assistants.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 23 HSCA 2008 (Regulated Activities) Regulations 2010 Supporting staff<br>We found evidence of a breach of Regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 [now Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014].<br>The registered provider did not have suitable arrangements in place to ensure that the persons employed for the purposes of carrying on the regulated activity were appropriately trained.<br>Regulation 23 (1) (a) |