Chineham Medical Practice

Quality Report

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Date of inspection visit: 17 February 2015
Date of publication: 06/08/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Chineham Medical Practice on 17 February 2015. Overall the practice is rated as good.

We found the practice to be good for providing safe, caring, effective, responsive and well led services.

It was also good for providing services for older people, people with long term conditions, working age and recently retired people, families, children and young people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Learning from incidents was not consistently shared with relevant staff members.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks, fire safety and portable electrical appliance testing.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff considered they had received training appropriate to their roles and any further training needs had been identified and planned for.
- 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.
- The practice had a number of policies and procedures to govern activity; these were in the process of being reviewed by the practice manager.
- Focus groups for particular population groups were held and included the use of online surveys where patients could respond to questions anonymously if they chose to.
- The registered manager was unfamiliar with the legal responsibilities of being a registered person.

Professor Steve Field CBE FRCP FFPH FRCGP

Summary of findings

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services as there are areas where it should make improvements. Staff understood had fulfilled their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong although reviews and investigations were thorough, lessons learnt were not communicated widely with relevant staff. Although risks to patients were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patients outcomes were at or above the 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 planned for. There was evidence of appraisals for staff. Staff worked with multidisciplinary teams to meet patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed the patients rated the practice higher than others for aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. We 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. Patients said they could make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had suitable facilities and equipment to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well led. It had a vision and strategy which was shared by staff who understood their

Summary of findings

responsibilities in fulfilling it. There was a leadership structure, but the registered manager was unaware of their legal responsibilities. The practice had a number of policies and procedures to govern activity; these were in the process of being reviewed. The practice proactively sought feedback from patients and had an active patient participation group.

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 provider was rated as good for providing services to older people.

The practice offered practice personalised care to meets the needs of older patients in its population and had a range of enhanced services, for example in end of life care. It was responsive to the needs of older patients and offered home visits, longer appointment times and same day appointments. All patients aged 75 years and older had a named GP. Patients with complex needs had a care plan in place.

People with long term conditions

Good

The provider was rated as good for providing service to people with long term conditions.

Nursing staff had lead roles in chronic disease management. Patients with long term conditions such as diabetes were offered an annual review and health check. The practice linked with a multidisciplinary team to provide support to patients with chronic obstructive pulmonary disease. Patients with long term conditions were able to book an appointment with a named GP to provide continuity of care. Longer appointment and home visits were available when needed. Smoking cessation clinics were offered at the practice.

Families, children and young people

Good

The provider was rated as good for providing services for families, children and young people.

There were systems in place to identify children who were at risk. The practice offered all NHS immunisations in line with current guidance. Children and young people were treated in an age appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and we saw good examples of working with midwives, health visitors and social workers.

Working age people (including those recently retired and students)

Good

The provider was rated as good for providing services for 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 adjusted the services

Summary of findings

it offered to ensure these were accessible, flexible and offered continuity of care. The practice offered online services as well as a full range of health promotion and screening that reflects the needs for this age group. Extended hours appointments were available in the evenings and on Saturday mornings. Patients who worked close to the practice were able to dual register, so they could access medical care if they were away from home.

People whose circumstances may make them vulnerable

Good

The provider was rated as good for providing services for people whose circumstances may make them vulnerable.

The practice carried out annual health checks for patients with a learning disability and offered longer appointments or home visits for this group of the population. The practice had a nominated lead GP for a local school for people with learning disabilities and worked with integrated teams to meet their needs. A list of patients who were also carers was kept by the practice. Patients who were travellers were offered flexible appointments. 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 provider was rated as for providing services for people experiencing poor mental health (including people with dementia).

A register was maintained for those patients with an enduring mental health condition and these patients were offered same day access and an annual health check. The practice was able to access a counsellor who worked on the premises. One of the GPs was the mental health lead for the clinical commission group. The practice worked with multi-disciplinary teams in the case management of this population group and carried out advanced care planning for patients living with dementia.

Summary of findings

What people who use the service say

We spoke with a total of nine patients on the day of the inspection and received a total of 11 completed comment cards. All patients considered that the practice was good, very good or excellent. Some of the comments cards named staff they considered to be to be caring. Other comments received, which were shared by the majority of respondents were that the practice was professional. In addition patients considered they were listened to and involved in their care and treatment. Two patients we spoke with said they had difficulty on occasion in getting a routine appointment, but were always seen on the same day, if their condition was urgent. Patients said they were treated with respect and their privacy and dignity was maintained.

Results from the national GP patient survey (January 2015) showed that 83% of respondents would recommend the practice to others; this was above the national average of 78%. Other areas where the practice scored above the national average included 97% of respondents having confidence and trust in the last GP they saw or spoke to (national figure 92%); and 86% said that nurses were good at listening to them (national figure 79%).

Chineham Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection was led by a CQC inspector and the team included a second CQC inspector; a GP specialist advisor; and a practice manager specialist advisor.

Background to Chineham Medical Practice

Chineham Medical Practice is situated at Reading Road, Chineham, Basingstoke, RG24 8ND. At the time of the inspection the practice had 11,579 patients registered with it. The practice has a higher than average proportion of patients in the 15-44 year age group. The practice is in an urban area, with an industrial site nearby.

The practice employs a total of 10 GPs, made up of seven partners and three salaried GPs. In addition there are three practice nurses; two healthcare assistants; eight reception staff; and eight administration staff and a practice manager.

The practice has a Primary medical services contract and is a training practice. The practice has opted out of out of hours provision, which is provided by HantsDoc via the 111 service.

The practice is open between 8am and 6.30pm Monday to Friday. Appointments are from 8.15am to 6pm daily. Extended hours surgeries are offered at the following times: Mondays until 7.30pm, and alternate Tuesdays until 7.30pm and alternate Saturday mornings from 8.15-10.45am.

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 17 February 2015 at Chineham Medical 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 11 comment cards where patients and members of the public shared their views and experiences of the service.

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

Detailed findings

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a patient's wound became infected following a minor surgical procedure and the practice found that a stitch had not been fully removed. Appropriate actions were taken to ensure this did not occur again.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. We found that learning from significant events and incidents was not routinely shared with relevant members of staff.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. Compliments received by the practice were also shared with staff. Records of significant events that had occurred were kept and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints, but meetings did not routinely involve relevant members of staff.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We sampled incident records and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result, for example, when a whooping cough vaccination had been given to a pregnant woman outside the recommended timeframe. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by a lead GP to practice staff. Staff we spoke with were able to give examples of recent alerts that were 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. Policies and procedures were also available on safeguarding adults and children. We found the adult safeguarding policy required updating to include information on the correct regulatory body, which is the CQC. The policy mentioned a previous regulator which is no longer in existence. We found the policies included information on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children respectively. They had been trained to the appropriate level for their role. Other staff who worked in the practice were currently undergoing refresher safeguarding training. We saw training plans which confirmed this. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. Staff knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example if a patient was a vulnerable adult or child.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting and treatment rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The policy indicated that all staff who acted as chaperone would have a criminal

records check via the Disclosure and Barring Service (DBS), unless a risk assessment had been carried out to identify it was not required. We found risk assessments had been carried out when needed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures of between five to eight degrees Celsius and there was information which described the action to take in the event of a potential failure. The practice staff followed the policy.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training to administer vaccines.

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 keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Nine patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and to carry out staff training. The infection control lead linked with the clinical commission group to share best practice. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. An action plan had been devised for the most recent audit and we saw that paper hand towel dispensers had been fitted, as this was an area which required improvement. The themes of the infection control audit were led by the clinical commissioning group and results were shared with them.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. We found the practice used a policy devised by the local NHS Trust, which although not specific to the practice was adequate for use. Personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to minimise the risk of cross infection. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Single use disposable equipment was used for minor surgical procedures.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand gel and hand towel dispensers were available in treatment rooms. There were designated foot operated pedal bins for clinical and general waste. Clinical waste contracts were in place and we saw evidence which confirmed this.

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 due to be tested as this had been identified as not having been carried out in line with legal guidance. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy in place which was last reviewed in January 2015 and aligned with the regulations. We looked at two staff files. One related to a member of staff who had been recruited in October 2014. We found there was an induction processes in place and a copy of their contract of employment. The practice's process for recruiting new staff had been followed and there was evidence of satisfactory checks on previous employment. The practice manager said that all clinical staff and staff who act as chaperone had a criminal records check carried out via the Disclosure and Barring service.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

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. However, there were shortfalls in these systems. Systems included checks of emergency lighting in February 2015 and fire extinguishers had been serviced on an annual basis. Measuring equipment had been calibrated in December 2014. The heating boiler had been serviced in November 2014. The practice had carried out a fire risk assessment in February 2015; the assessment showed that portable appliance testing had not been carried out in line with relevant guidance. The practice manager had arranged for this to happen. These systems and policies were under review to ensure they were effective and protect patients from harm.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had received training in basic life support. 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.). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was 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 whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that impacted on the daily operation of the practice. Risks identified included flood risk, power failure and adverse weather. The document also contained relevant contact details for staff to refer to. This plan was in the process of being updated to ensure all information was current.

The fire risk assessment showed that fire drills had not been carried out six monthly in line with recognised guidance and these were to be reinstated. The fixed electrical wiring system was due a five yearly inspection and service. Fire safety training had been booked for all staff in March 2015.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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 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 the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. 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.

The GPs told us they lead 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 open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local clinical commissioning group of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. For example, those with long term conditions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us examples clinical audits that had been undertaken in the last 12 months. For example, an audit was carried out on correct insertion of intrauterine contraceptive devices and implants. The audit covered the work of a GP at the practice and a doctor training to be a GP. Results from this audit showed that there were no incidents of harm or infection. A re-audit was carried out six months later, which again showed that both clinicians were competent at carrying out these procedures.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotics. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 81% of patients with diabetes had an annual review. This practice was an outlier for Chronic Obstructive Pulmonary Disease (lung disease), due to the higher number of patients when compared to the national average aged under 65 years.

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 that the latest prescribing guidance was being used. The practice IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question

Good

Are services effective?

(for example, treatment is effective)

and, where they continued to prescribe it outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

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

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that there were gaps against several names, which indicated they had not received training. We were unable to verify whether training had occurred, but had not been recorded. However, the practice manager was auditing all staff records to identify gaps in training and implement learning where needed. All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

One of the GPS was a qualified surgeon and was responsible for undertaking all minor surgery performed at the practice. This GP was also responsible for auditing their practice and ensuring consent was correctly obtained prior to a procedure being carried out.

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with. The practice manager said that the appraisal policy had been reviewed to give a greater emphasis on training and development.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example seeing patients with long term conditions such as asthma or diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

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

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately. GPs were able to set a task on the computer system to ensure referrals were made to secondary services in a timely manner and not missed.

The practice held multidisciplinary team meetings at least monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice provide a room free of charge for Age UK to provide podiatry services to older patients and the practice was able to access an on call consultant who treated older patients for advice and support.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making

referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system, 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. Information on patients with complex needs, who had a care plan in place and those who had completed a do not resuscitate directive was shared through the computer system with other providers.

GPs in the practice were able to securely access Hampshire Health Records from their own homes, if needed, to monitor patients test results and take appropriate action.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005. 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. Some staff had received training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, which they had found to be useful. Training on these subjects was being arranged for other staff that required it.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of 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). Children aged between 13 and 16 years old were able to make an appointment either in person or via the telephone. Once they had reached the age of 16 years old, then they were able to access appointments via the online system. GPs explained this was to protect their confidentiality and allow them to discuss concerns with the practice that they may not want their parents or guardians to know about initially.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure, along with a completed written consent form. Patients received a copy of the consent form.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 74 years. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and they were offered an annual physical health check. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. The practice participated in national screening programmes and offered cervical, breast and bowel screening services.

The practice's performance for cervical smear uptake was 82%, which was in line with the national average. Patients who were diabetic were offered foot examinations and cholesterol checks. Data from the Quality and Outcomes framework showed that 85% of diabetic patients had their feet examined and 74% had a cholesterol level check. These results were marginally below the national average.

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 CCG, and again there was a clear policy for following up non-attenders by

Good

Are services effective?

(for example, treatment is effective)

the named practice nurse. The practice had patients who were part of a travelling community and ensured that when they presented for immunisations these were done on the same day.

Information on health promotion was displayed on a TV screen in the waiting room and we saw there were leaflets available on conditions, such as Parkinson's disease and information regarding alcohol consumption. Information on sexual health and chlamydia was displayed in patients' toilets. The practice website also had links to health information and support agencies for patients.

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 January 2015 and a survey of 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. For example, 86% of national patient survey respondents said the last GP they saw or spoke to good at treating them with care concern. (The national average was 82%). Ninety percent of respondents said that nurses were good at treating them with care and concern, which exceeded the national average of 78%.

Other data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also well above average for its satisfaction scores on consultations with doctors and nurses with 89% of practice respondents saying the GP was good at listening to them and 90% saying the GP gave them enough time.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk in a sectioned off area which helped keep patient information private.

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 84% of practice respondents said the GP involved them in care decisions and 83% felt the GP was good at explaining treatment and results. Both these results were at or above average compared to national results.

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

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93.5% of respondents to the Patient Participant Group survey said the practice met or exceeded expectations overall. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. The practice also signposted bereaved families to other support organisations for bereavement counselling.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. In response to patient feedback and suggestions from the patient participation group, the practice had installed a new telephone system to assist staff to manage telephone calls more efficiently. The new system was being actively monitored, as there were still occasions where patients were held in a queue for longer than the practice considered to be desirable. Results from the national patient survey showed that 77% of respondents found it easy to get through to the practice on the telephone, compared to a national average of 72%.

The practice had a higher than average proportion patients who were of working age. The practice had tailored its services to meet this patient group expectations, a GP said that quite often second opinions from other health professionals were sought and the practice would try and accommodate this if clinically necessary. Patients who worked near the practice were able to register with them so that they could access medical care and treatment when away from home. Any care or treatment given was shared with their usual GP.

Results from the national patient survey showed that 76% of respondents were satisfied with the surgery's opening hours which was in line with the national average.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients with learning disabilities or travelling communities. Patients with learning disabilities were offered longer appointment times. Patients who were travellers were offered flexible times for appointments and longer appointments if needed. The practice provided a lead GP for a local special needs school and a care home for patients with learning disabilities.

The practice worked with an integrated care team to offer holistic support and treatment for patients, such as those with mental health needs.

The premises and services had been adapted to meet the needs of patients with disabilities. Consulting rooms were on the ground and first floor of the practice. There was a lift that patients could use. The practice would try and organise rooms on the ground floor for patients with limited mobility. The first floor consulting rooms tended to be used by a visiting midwife and health care assistants for clinics. The practice had a hearing loop installed for patients who had impaired hearing.

The practice had access to online and telephone translation services.

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8.15am until 6pm on weekdays. These extended to 7.30pm on Mondays and alternate Tuesdays. A Saturday morning session was held on alternate Saturdays between 8.15 to 10.45am. These included nurse as well as GP pre bookable appointments. The practice offered same day appointments with a nurse or GP, following triage by a duty GP. Phlebotomy services were available on site.

The practice had a travelling community who used the services. The practice had experienced appointments being made, but not kept by patients in this population group. The practice responded by seeing this group of patients when they presented at the practice.

Longer appointments were also available for patients who needed them, including patients with long-term conditions. This also included appointments with a named GP or nurse.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they had called that morning for an appointment for a GP to see their child who was unwell.

A total of 91% of respondents to the national GP patient survey said that the last appointment they got was convenient and 76% described the experience of making an appointment as good. Both these results were in line with the national average.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. We found that there was information about how to contact NHS England or the local Healthwatch, if a patient was not satisfied with the practice's response. But there was no information about contacting the Health Ombudsman. 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. For example, posters and leaflets were available in the waiting area. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice. All telephone calls to the practice were recorded and this assisted them in dealing with concerns raised about how patients were spoken with. An automated message informing patients of this was given when a patient contact the practice by telephone.

We looked at 10 complaints received in the last 12 months and found that these were handed in a timely way and action taken if needed to resolve the complaint to the patient's satisfaction when possible. Records held confirmed this.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The main aim of the practice was to put patients at the centre of the care provided. Staff knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. The practice manager explained they were in the process of reviewing all policies and procedures to ensure they were up to date. We examined a sample of the policies and found that the training policy was under review, along with the health and safety policy.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a salaried GP was the lead for safeguarding. We spoke with staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. The practice QOF results for 2013/14 were 91.9% compared with a practice average across England of 94.2%. The practice shared with us the current figures for 2014/15, which showed improvements had been made. However, the final results would not be signed off until April 2015 when the QOF year had ended. We saw that QOF data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes. Minutes of meetings confirmed this. The practice had an ongoing 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. For example, infection control audits. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

The systems and processes in place required improvements to ensure that the practice was safe and well led. We found that the person who was the registered manager was not aware of their legal obligations in terms of the CQC registration. Learning and improvement from significant events, incidents and complaints had not been consistently shared with relevant staff. Arrangements to manage risk associated with fire safety did not ensure that patients were kept safe. For example, the practice had not carried out regular fire drills and recorded them.

The practice had a named Caldicott lead who was responsible for information handling in the practice, who had received training on this area and was responsible for managing information within the practice.

Leadership, openness and transparency

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.

The practice manager was in the process of reviewing all policies and procedures and said that a staff handbook would be devised once this process had been completed.

The chair of the patient participation group (PPG) said that the partners shared information on changes to the staff team with them and the PPG was able to provide feedback. An example given related to a GP who had reduced their hours and the practice was able to employ a GP who had trained at the practice as a partner.

The registered manager for the practice was not consistently involved in the day to day running of the practice. The partners said that this situation would be reviewed.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys and complaints. We looked at the results of the annual patient survey where patients had raised concerns about telephone access and saw that arrangements were made to improve this and these actions were being monitored.

The practice had implemented a bi-monthly meeting for reception and administration staff to provide time for these

Are services well-led?

Good

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

teams to discuss matters which affected their work. The meetings were chaired by the practice manager or the office manager and when needed feedback was provided to the GP partners.

The practice had an active patient participation group (PPG). We met with the chair of the group. The chair considered that the practice responded well to patients' requests and suggestions. They added that patients registered with the practice would ask searching questions of the practice, to which the practice responded well. The PPG included representatives from various population groups; including working age patients and older patients. The PPG carried out surveys and met regularly. The chair of the PPG said that the response to surveys was good and they were continuing to see an increase in the number of patients who participated in surveys. Focus groups for particular populations were held and included the use of online surveys where patients could respond to questions anonymously if they chose to. A survey held last year showed that patients sometimes had to wait up to 45 minutes after their appointment time, before seeing a GP. The PPG had informed the practice of this and a protocol was put into place to inform patients of any delays in being seen 20 minutes after the appointment time. The results and actions agreed from these surveys are available on the practice website.

The PPG produced a quarterly newsletter whose contents were discussed with the practice manager. The practice also contributed articles on health promotion and how a GP practice was run, to the local Parish magazine. The PPG also attended flu clinics and used the opportunity to survey patients about their experience of using the service.

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 appraisals under the new system had taken place and included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Staff received appraisals and considered that their learning needs were identified and planned for. However, there was a lack of collated information on the training staff had attended or what had been planned. The practice manager had implemented a new appraisal system, which covered these areas and was developing a record of staff training received and required. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice was a GP training practice and support was provided to GPs in training and longer appointment times.