Regents Park Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Regents Park Surgery, Park Street, Shirley, Southampton, SO16 4RJ on 14 April 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 the care of older people, people with long-term conditions, care of families, children and young people, working-age people (including those recently retired and students),care of 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.
- Risks to patients were assessed and well managed.
- The practice's performance for the cervical screening programme was 100%, which was well above the national average of 81.89%.
- 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.
- The practice had responded to an increase in Polish patients by employing a Polish speaking receptionist.
- 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.

Summary of findings

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for 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. 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 locally. 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 for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained their 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. The practice had responded to an increase in Polish patients by employing a Polish speaking receptionist. 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

Summary of findings

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. 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. It had a clear vision and strategy. 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 it acted on. The patient participation group was active. Staff had received inductions, regular performance reviews 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 the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. 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. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were 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. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that 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 the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

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 the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

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 reflects the needs for this age group.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and these patients had received a check-up. 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. It had told vulnerable patients about 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). Data supplied by the practice showed that 95% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended the local accident and emergency department when they had been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

The local community mental health service was based within walking distance of the practice. The local Improving Access to Psychological Therapies (IAPT) is a national NHS programme increasing the availability of services across England offering treatments for people with depression and anxiety disorders. The IAPTS service offers counselling to patients at the practice premises.

Summary of findings

The practice had a memory advisor who has recently started working with in this locality. This person supported patients and families of those with dementia. The practice also had access to the Admiral nursing services for dementia. Admiral nurses are specialist dementia nurses who give much-needed practical and emotional support to family carers, as well as the person with dementia.

Summary of findings

What people who use the service say

We received 11 completed patient comment cards and spoke with five patients at the time of our inspection visit.

Of the 11 people who provided feedback all of the comments were very positive about the practice as a whole and patients reported that all the staff were caring and helpful, and treated patients with dignity and respect.

Patients we spoke with were positive about the care and treatment provided by the GPs and nurses and the assistance provided by other members of the practice team. They told us that they were treated with dignity and respect and some commented that the care provided was excellent.

In a GP patient survey conducted in 2014 on behalf of NHS England 84.6% of the respondents described their overall experience of the GP surgery as fairly good or very good this was similar to the national average.

Feedback placed on the NHS choices website was both positive and negative about the service received by patients. Although there appeared to more positive feedback in the previous five months.

There was a patient participation group known as the Friends of Regents Park Surgery in place and this group supported the practice with their surveys. Requests for volunteers to join the PPG were advertised through the practice website, leaflet and on posters displayed in the waiting area.

Regents Park Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist advisor.

Background to Regents Park Surgery

Regents Park Surgery, Park Street, Shirley, Southampton, SO16 4RJ, was a long standing practice established in 1991 in a purpose built surgery owned by the GP partners. The practice located in the western area of the City of Southampton and covered an urban area with a mixed demographic make-up of differing health needs and area of diabetes, drugs misuse, obesity, smoking and teenage pregnancy had all been identified as areas of priority. The practice was close to Southampton General Hospital.

The practice at the time of our visit had four partner GPs two male and two female with a whole time equivalent of three. The practice employed two practice nurses and a health care assistant working a total of 63 hours per week. The clinical team were supported by a full time practice manager and part time reception manager, medical secretary, medical administrator, administration assistant and a team of seven part time reception staff. The practice also had a full time administration apprentice. The practice held a general medical services contract with the Southampton Clinical Commissioning Group and had a stable patient list of just less than 6000.

The practice was open between 8:30am -12:30pm and 2:00pm and 6:00pm, Monday to Friday, urgent appointments could take place between 8:00am and 6:30pm. Appointments were a mixture of 10 minute pre-bookable appointments up to two weeks in advance and a book on the day clinic running twice daily from Monday to Friday. One GP assumed the responsibility of duty GP and saw urgent cases and carried out home visits which were divided into mornings and afternoons. GPs would usually visit their own patients if possible. The practice had made a decision after investigation to stop providing extended hours.

The practice had become part of the Southampton Federation which had successfully bid for funding under the Prime Minister's challenge fund. The bid will provide access to both urgent and long-term condition care eight until eight, seven days a week.

When the practice was closed and patients had an urgent problem which could not wait until the practice re opened they were advised to call 111. The service was available 24 hours, seven days a week including Bank Holidays. Patients were then directed to an out-of-hours service.

The practice also hosted the Community Nursing Team from NHS Solent and they had weekly visiting community services such as midwifery and therapist.

This was a teaching practice and teaches year two and four and final year medical students from the University of Southampton. The practice GPs were members of the Wessex GP Educational trust and is a research practice.

The practice has a group representing the patients known as the Friends of Regents Park Surgery. This was a voluntary group of patients from the practice who joined to find ways of supporting the practice staff and extending services by providing equipment that benefitted the patients. They also represented the views of patients and assisted with patient surveys.

Detailed findings

The practice was last inspected by the Care Quality Commission in February 2014 under our previous inspection methodology. The practice met all the required standards during that inspection.

Why we carried out this inspection

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

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 we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on the NHS Choices website.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with patients who used the practice. We reviewed comment cards and feedback where patients and members of the public shared their views and experiences of the practice before and during our visit.

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 prioritised safety and 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 on a medicine audit a carer had been found to be giving an incorrect dosage of medicine to the patient after the patient had misinterpreted the dosage after instruction. The action taken to prevent the incident happening again was for dosage to be confirmed by prescription dose and tablet colour.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. This showed the practice had managed these consistently and so could show evidence of a safe track record over the long term. The practice had recently attended training and was moving to reporting patient safety incidents in line with the national reporting and learning system that had been published by NHS England in February 2015.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of three significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. 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.

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 tracked one incident and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared an example seen was where a patient, who was not registered at the practice, attended with chest pain, the patient was treated in accordance with the practice's chest pain protocol. The emergency services were called but the patient was treated successfully at the practice, was registered as a temporary patient and did not require to be sent to the accident and emergency at the local hospital. This was reported as a positive outcome by the practice.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by direct notification and follow up at team meetings 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. They also told us alerts were discussed at meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training and staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and 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. The practice policies on safeguarding had been reviewed and updated in December 2014.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

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 children subject to

child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (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 and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person had a criminal record or was on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice attended children protection case conferences and reviews and met every six weeks with the health visitors to discuss 'at risk' vulnerable children. Reports were sent if staff unable to attend and case conferences.

The practice had systems to highlight vulnerable patients and place alerts on their notes to assist the GPs there was also a system for reviewing repeat medications for patients with co-morbidities/multiple medications.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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. We saw that the practice prescribed Meloxicam to reduce inflammation and pain; which explained the low percentage use of alternative medicines such as Naproxen and Ibuprofen as found in the quality outcomes framework results. There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked anonymised patient records which confirmed that the system was being followed.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

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. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures which were dated January 2014 were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with

the practice's infection control policy. For example members of staff had specific roles defined in the policy there was a clinical lead, non clinical lead and staff member responsible for 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 carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits the last being conducted 1 April 2015 and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand gel and sanitising hand paper towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment on 29 January 2015 for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

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. A schedule of testing was in place. We saw evidence of servicing and testing of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, conduct in previous employment, qualifications, registration with the appropriate professional body and the appropriate checks through 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. The practice did on some occasions employ locums and followed their own recruitment procedures.

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. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

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 regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Risks associated with service and staffing changes (both planned and unplanned) were addressed. We saw an example of this as the practice was future proofing the practice and had actively sought to recruit a new partner when one of the partners had notified the practice that they had decided to leave the practice. Meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: monitoring patients in the waiting area which could be viewed from the reception.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that staff had received training in basic life support and further training had been arranged for the whole practice in June 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic

Good

Are services safe?

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. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Emergency medicines were easily accessible to staff 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 may impact on the daily operation of the practice. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The practice had arranged a buddy system with another local practice which was about the same size and the practice was able to transfer the computer system to be used at the other practice if required. There was an information pack available for staff to refer to and wall crib sheets with information, for example the location of the water, gas and electricity emergency switches. As part of new staff induction they were shown where these switches were.

The practice had carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. The fire alarms and emergency lighting were last serviced in February 2015. All the fire extinguishers were serviced in January 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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes had regular health checks and were referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The nurses 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. We saw that the practice had an appointment information card which was used by reception staff to ensure that patients were booked in with nurses who were qualified and able to deal with the specific requirements of the patient. For example patients needing hypertension reviews were allotted a 20 minute appointment with nurses.

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 review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. 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 information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last two years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. 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 medicines to treat epilepsy and the strength of dose. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it met with national guidelines. The practice also worked closely with the pharmacy advisor to ensure they aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96.7% of the total QOF target in 2013-2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average
- Performance for mental health related and hypertension QOF indicators was similar to the national average.
- The dementia diagnosis rate was comparable to the national average.

The practice was aware of all the areas where performance was not in line with national or clinical commissioning group figures and we saw evidence of how these had been addressed.

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.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It 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.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example homeless, travellers and patients with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions for example Diabetes, chronic obstructive pulmonary disease, and Heart failure.

The practice participated in local benchmarking run by the clinical commissioning group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example the practice was part of the Southampton diabetes accreditation scheme, in which patients (apart from complex patients such as those who are pregnant or have kidney disease) are seen by the practice diabetes nurse. Clinics were held at the practice, with advice and expertise readily available from the specialist diabetes team. This had the benefit of up skilling practice staff as well as being more convenient for patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with one having special interests included ear, nose and throat problems and family planning and another had special interest in diabetes and joint injections. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and 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).

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. 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.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and diabetes care. Those with extended roles as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

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 these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. 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.

Emergency hospital admission rates for the practice were similar to expected at 16.8% compared to the national average of 13.6%. We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook audits of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings every four to six weeks to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers and health workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used 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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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. Staff we spoke with 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. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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.

Good

Are services effective?

(for example, treatment is effective)

Clinical staff demonstrated a clear understanding of the Gillick competency test. (This used to help assess whether a child under the age of 16 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 patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure.

Health promotion and prevention

It was practice policy to offer a health check 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 opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Patients are involved in their care and all new patients have access to their clinical records and are provided with a comprehensive welcome to the practice pack. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years.

The practice's performance for the cervical screening programme was 100%, which was well above the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The GPs had clinical responsibility to promote this and the practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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 was above average for the majority of immunisations where comparative data was available. For example:

• Flu vaccination rates for the over 65s were 71.82%, and at risk groups 53.55%. These were similar to national averages.

• Childhood immunisation rates for the vaccinations given to under twos ranged from 92% to 100% and five year olds from 66.67% to 100%. These were comparable to national averages.

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 2014, a survey of 108 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires completed by patients. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

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, data from the national patient survey showed the practice was rated as similar to expected for patients who rated the practice as good or very good. The practice was also similar to the national scores for its satisfaction scores on consultations with doctors and nurses. For example:

- 84.64% of respondents to a national NHS England patient survey described their overall experience of their GP surgery as good compared to the national average of 85%.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 11 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

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 and the desk was shielded by glass partitions which helped keep patient information private. A system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff the practice also had music playing in the waiting area which helped to prevent conversations being overheard. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, patients said they found the receptionists at the practice helpful and treated them with respect and dignity.

Patients whose circumstances may make them vulnerable we able to access the practice without fear of stigma or prejudice and a GP explained that staff treated people from these groups in a sensitive manner. Examples were given of travelling families that were hard to reach but were welcomed at the practice.

The practice had not been asked to register someone who was homeless or a traveller for several years; this was probably because the homeless healthcare team holds the contract to provide services to such patients and offered a very specialised and tailored service to their unique needs. However the practice would not decline to register such a patient, should they wish to join the practice.

The practice had a number of patients, who either had learning disabilities, or who had varying degrees of cognitive impairment, some such patients were well supported in the community and some live alone. Continuity of care means that staff knew those patients who may not be able to articulate their needs clearly, who needed extra time or needed information given in a particular way.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

Good

Are services caring?

There was a visible notice in the patient reception area and on the practice website stating the practice's zero tolerance for abusive behaviour in line with NHS policy. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

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:

• 80.95% said the GP was good at involving them in decisions about their care and national average of 81.84%.

• 85.83% said the nurse they saw was good at involving them in decisions about their care compared to the national average of 85.11%

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt 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.

The practice provided prenatal advice, postnatal care and examinations at six weeks after birth.

The practice was mindful of the issues around confidentiality and capacity, and saw and treated children under the age of 16 unaccompanied (with a chaperone if appropriate) if that is the choice of the young person and the practice deemed them to be competent.

Patient/carer support to cope emotionally with care and treatment

The NHS England patient survey 2014 information we reviewed showed patients were positive about the emotional support provided by the practice and rated it similar to expected in this area. For example:

• 80.89% said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85.31%.

• 90.32% said the last nurse they spoke to was good at treating them with care and concern compared to the national average.

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, they 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 website information available for carers to ensure they understood the various avenues of support available to them. This was under an area called carers direct and sign posted carers to support available from the practice.

The practice website had a section assisting patients with bereavement. This gave advice on what to do and we were told that GP usually made contact with the families to assist were required.

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. The practice had written care plans for at least 2% of the patient population, the majority of whom were elderly. These care plans were co-produced, and very much person centred with an emphasis on the persons own goals and wishes rather than being a medically driven care plan.

The practice engaged regularly with the NHS England Area Team and Clinical Commissioning Group (CCG) 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 to better meet the needs of its population. For example standing items on all clinical meetings were, risk profiling, unplanned admissions, care plan register, community pharmacy.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). As a result of surveys the practice had implemented on line appointment booking and text message reminders to mobile phones. Patients could receive information by text message on their phone regarding appointments and health care. Patients had to register for this service and sign a consent form.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. The practice had responded to an increase in Polish patients by employing a Polish speaking receptionist.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The practice had installed a hearing loop for patients with hearing difficulties.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The practice was open between 8:30am -12:30pm and 2pm and 6pm, Monday to Friday. Appointments were a mixture of 10 minute pre-bookable appointments up to two weeks in advance and book on the day clinic running twice daily from Monday to Friday. One GP assumed the responsibility of duty GP and saw urgent cases and carry out home visits which were divided into mornings and afternoons. GPs usually visited their own patients if possible.

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 on the out-of-hours service was provided to patients on the website.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice similar to expected in these areas. For example:

- 77.53% were satisfied with the practice's opening hours compared to the national average of 79.83%.
- 86.64% said they could get through easily to the surgery by phone compared to the national average of 75.4%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine

Good

Are services responsive to people's needs?

(for example, to feedback?)

appointments were available for booking up to two weeks in advance. Comments received from patients also 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 there were daily urgent appointments available both morning and afternoon.

The practice always tried to accommodate patients with early or late appointments for services such as medication reviews, long-term condition reviews and phlebotomy.

The practice had audited extended hours, which used to be provided and found that very few of them were actually being used by working age adults, and the hours were not popular with patients. The practice had an online booking system available and was easy to use, text message reminder for appointments and test results, online or telephone consultations where appropriate, support to enable people to return to work.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system there were posters displayed, a summary leaflet available and information on the practice website. Patients we spoke with were aware that there was a 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 and said they would speak with the practice manager if they had any concerns.

We looked at 13 complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, and showed openness and transparency in dealing with the compliant. The practice reviewed complaints annually to detect themes or trends. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. Examples seen in response to complaints were extra training given to staff and reassurance visits made to patients.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and 2015 year statement of purpose. This included such things as the delivery of services of a high standard pertaining to the needs of our local community. To ensure high quality, safe and effective services and environment. To prevent ill health, improve wellbeing and provide services that improve local health outcomes.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

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 on any computer within the practice. We looked at 10 of these policies and procedures and most staff had confirmed that they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date. All policy documents were made available to all staff on the practices computer systems.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Quality and Outcomes Framework to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example an audit of prescribing policy and how the audits results were shared with the GP team. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example a recent legionella risk assessment that took place in January 2015. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example Infection control policy and Safeguarding policy which were in place to support staff. Staff we spoke with knew where to find these policies if required.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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 the senior partner was the lead for safeguarding. We spoke with members of 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.

We saw from minutes that team business meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Are services well-led?

Good

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

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), known as the Friends of Regents Park Surgery, surveys and complaints received. It had an active PPG which included representatives from various population groups. The PPG had carried out surveys and met every quarter. We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. The Friends of Regents Park had purchased a Doppler Machine in March 2104.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three 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 that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice and teaches year two and four and final year medical students from the University of Southampton. The practice GPs are members of the Wessex GP Educational trust and the practice was a level 1 primary care research network practice. Being involved in research strengthened the evidence base for prevention, diagnosis, treatment and management of illness and disease in primary care.