The Denmead Practice

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?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Denmead Practice on 9 July 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing responsive, caring, effective and well-led services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances may make them vulnerable and people experiencing poor mental health. It required improvement for providing safe services.

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, with the exception of those relating to medicines management.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles but further training needs and clinical supervision had not been identified or provided for all staff.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management.

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on.
- 97% of respondents to a national patient survey, published in January 2015, said their overall experience of the practice was good.
- Quality and outcome framework data for this practice in 2013/14 showed it had met 98.7% of the outcomes. This was higher than the national average of 94.2% for GP practices.

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

Importantly the provider must:

- Ensure out of date medicines are identified and disposed of and appropriate records are kept for Controlled Drugs as well as the prescription pads kept in GP emergency bags.

In addition the provider should:

- Ensure all fire safety checks are carried out.
- Obtain evidence that cleaning audits have been carried out by the external cleaning company and record visual checks carried out by the infection control lead.
- Ensure all staff receives fire safety training.
- Ensure all clinical staff receive supervision and access to relevant continuing professional development relevant to their roles.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. Although risks to patients who used services were assessed, the systems and processes to address these risks were not implemented well enough to ensure patients were kept safe. The area of concern found was in relation to management and record keeping of medicines including Controlled Drugs and associated stationary within GP bags.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked with multidisciplinary teams. There was evidence of appraisals but some staff were not accessing continuing professional development or supervision relevant to their roles.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Data aligned with this and showed that patients rated the practice higher than others for several aspects of care. 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 confidentiality.

Are services responsive to people's needs?

Good

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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. 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 (PPG) 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 also 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. For dispensing patients' larger print labels, and or "reminder cards" were available. Non-child resistant lids and "popping blister packs" out into "pots" were offered to those with reduced hand dexterity.

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 A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. 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 reflected the needs of 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 61% of the patients invited had received a follow-up. It also 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 and 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). 95% of people experiencing poor mental health had their care plan reviewed and documented in the preceding 12 months. 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 signposted patients experiencing poor mental health to various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. Staff had received training on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We received 46 completed patient comment cards and asked 33 patients for their views at the time of our inspection visit. These included older patients, mothers with babies, vulnerable patients and patients of working age. We spoke with GPs, nursing staff, administration staff, and the practice management team.

All of the patients we spoke with and who completed Care Quality Commission comment cards were very positive about the care and treatment provided by the GPs and nurses and other members of the practice team. Everyone told us they were treated with dignity and respect and that the care provided by the GPs, nursing staff and administration staff was of a high standard. Comments included reference to the practice being caring, staff being friendly, willing to help and polite.

The practice had a virtual patient participation group. This group was a way for patients and the practice to listen to each other and work together to improve services, promote health and improve the quality of care. Results of surveys were available to patients on the practice website alongside the actions agreed as a result of the patient feedback.

We also looked at the results of the 2014 GP patient survey which was published in January 2015. This is an independent survey on behalf of NHS England. The survey showed that the practice achieved better than average results for the local area and nationally, these results included;

• 97% of respondents said they would recommend the practice to someone new to the area.

- 94% of respondents said it was easy to get through to the practice by phone.
- 95% of respondents said they were able to get an appointment to see or speak to someone the last time they tried.
- 97% of respondents described their overall experience of the practice as good.

Areas for improvement

Action the service MUST take to improve

- Ensure out of date medicines are identified and disposed of and appropriate records are kept for Controlled Drugs and medicines related stationary within GP bags.

Action the service SHOULD take to improve

- Ensure all fire safety checks are carried out.
- Obtain evidence that cleaning audits have been carried out by the external cleaning company and record visual checks carried out by the infection control lead.
- Ensure all staff receives fire safety training.
- Ensure all clinical staff receive supervision and access to relevant continuing professional development relevant to their roles.

The Denmead Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector.

The team included a GP specialist advisor and a practice manager specialist advisor.

Background to The Denmead Practice

The Denmead Practice is a dispensing practice situated in Denmead which is a rural area north of Portsmouth, Hampshire. The practice has an NHS general medical services contract to provide health services to approximately 9,100 patients.

Appointments are available between 8.30am and 6pm from Monday to Friday. Evening appointments are also available on Mondays and Tuesdays between 6.30pm and 8pm. The practice has opted out of providing out-of-hours services to their own patients and refers them to Portsmouth Healthcare Limited via the NHS 111 service.

The mix of patients' gender (male/female) is almost half and half. Approximately 30% of patients are aged over 60 years old which is higher than the average for England. The practice is located in a semi-rural area of low deprivation.

The practice has five GP partners who together work an equivalent of 3.8 full time staff. There are three male and two female GPs. The practice also has a nurse practitioner, two practice nurses and a health care assistant. The GPs and the nursing staff are supported by a team of eight reception staff, five administrators, three dispensing technicians, an assistant practice manager and a practice manager.

We carried out our inspection at the practice's main location which is situated at:

Denmead Health Centre

Hambledon Road

Denmead

Waterlooville

Hampshire

PO7 6NR

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.

Detailed findings

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)

Requires improvement

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 responsibility to raise concerns, and knew how to report incidents and near misses. All alerts arrived via a generic email inbox the practice had set up and the deputy practice manager printed them off and circulated them to relevant staff. Alerts had a tick and signature sheet. We were told staff who hadn't read it were chased up. One example of an alert was about a person requesting to register with GP practices and fraudulently requesting prescribed medicines.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. Safety alerts relating to medicines were received by the practice manager and directly by dispensary staff from the pharmaceutical wholesalers. The dispensary staff would action the alert if required, record any actions taken including 'no action required', then inform the practice manager. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 27 significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held bi-annually 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 who showed us the system used to manage and monitor incidents. We tracked three incidents 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. For example, a patient's blood pressure reading was entered onto another patient's records. Learning was seen by way of a change in the practice protocol which included patients being asked to add their date of birth to their blood pressure readings before they passed it to staff to update their record. 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.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. 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.

A GP partner was the lead in safeguarding vulnerable adults and children and could demonstrate they had received level three safeguarding children training and had the necessary skills to enable them to fulfil this role. All staff we spoke with were aware who the lead was if they had a safeguarding concern. Of the remaining four GPs and four practice nurses, all had received an appropriate level of safeguarding children training. For example, GPs had level three and nurses had level two safeguarding training except the nurse practitioner who had level three training.

Other staff working at the practice included dispensary and administration staff. Of these, 15 out of 18 had received the appropriate level of safeguarding children training and 12 had received safeguarding adults training.

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.

Requires improvement

Are services safe?

The practice had a chaperone policy, which was visible on the waiting room noticeboard, 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 chaperones were nurses and had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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, except for one refrigerator, which was not secure allowing unauthorised access. Records showed room temperature and fridge temperature checks were carried out to check medicines were stored at the appropriate temperature. Occasionally medicines were transported from the main practice to the branch practice for patients to collect. However, the practice was not monitoring the temperature of medicines requiring refrigeration whilst being transported and therefore could not provide assurance that these medicines were being maintained within their recommended temperature range.

Processes were in place to check medicines were within their expiry date and suitable for use including expiry date checking. However, we found two items within a GP emergency bag that were out of date. Nurses used Patient Group Directions (PGDs) to administer vaccines that had been produced in line with legal requirements and national guidance. We saw sets of in date PGDs signed by a person legally allowed to prescribe medicines.

Whilst most prescriptions were for 28 days, prescriptions of shorter durations may be issued where clinically appropriate. All non-dispensing and repeat dispensing patient prescriptions were reviewed and signed by a GP before they were given to the patient. Acute dispensing patient prescriptions were signed at the end of each session. Both blank prescription forms for use in printers and those for hand written prescriptions were stored and tracked on-site in accordance with national guidelines. However, the hand written prescription forms held by GPs were not managed in accordance with these.

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 not being followed by all the practice staff. Discrepancies had been recently identified in two controlled drug registers.

The practice explained the investigations they had undertaken and the involvement of the Controlled Drugs Senior Manager from the NHS England Area Team.

At the time of the inspection, the discrepancies for one controlled drug register had been resolved and the other investigation was on going and had identified that a number of administrations had not been recorded in the register.

Additionally whilst there were arrangements in place for the destruction of controlled drugs they were not being followed in a timely manner. For example, some controlled drugs had been awaiting destruction since 2013.

The controlled drugs were stored securely, access to them was restricted and the keys held securely.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained.

The practice had established a service for patients to pick up their dispensed prescriptions at their branch surgery and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy. All the patients we asked told us they found the practice clean and had no concerns about cleanliness or infection control. We saw there were cleaning schedules in place for nursing staff and records were kept. Staff told us that the practice was cleaned by contract cleaners. We were told that the contract cleaning company audited their staff regularly but

the infection control lead was not provided with evidence of this. The infection control lead told us they carried out visual inspections of the cleaning standard but did not record this.

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. 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. There was also a protocol for needle stick injury and staff knew the procedure to follow in the event of an injury.

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. We saw evidence that the practice 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. For example, food was found in the medicines refrigerator in the dispensary. This was discussed at a staff meeting on 21 May 2015 which advised staff to not do this and we were told food was not placed in medicines fridges again. On inspection we found this action had been effective.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice had undertaken a risk assessment for legionella in October 2012 and necessary water quality checks were being made.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was July 2014 and the date for the next test was planned for the week following our inspection. We saw evidence to confirm that relevant medical equipment had been serviced and calibrated in July 2015 to check it worked properly. Items tested included, weighing scales, spirometers, blood pressure measuring devices and nebulisers.

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, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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. Newly appointed staff had this expectation written in their contracts.

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. The practice had a health and safety policy. Risks identified included lone working, violence and aggression to staff, and fire safety and substances hazardous to health (COSHH).

The practice carried out regular checks of the building, the environment, medicines storage, staffing, dealing with

emergencies and equipment. A COSHH risk assessment had been carried out in April 2015 and as a result information data sheets were made available for staff to refer to when using substances hazardous to health. These generally being cleaning products. One area that that required improvement was the irregularity of monthly emergency lighting tests. The practice carried out five tests over the past 15 months. Another risk assessment seen was for the practice wheelchair. This was carried in in May 2015 and confirmed the wheelchair was safe to be used by patients.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 25 out of 28 staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). Staff all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in the practice and; all staff knew of the locations. Processes were also in place to check emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

An emergency/business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. 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 plan was last reviewed in February 2015. Mutual emergency support arrangements with a local GP practice was detailed in the business continuity plan which ensured patient care was maintained in the event of an emergency which closed the Denmead Practice.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that 13 out of 28 staff had received fire safety training in the previous six months.

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 practice manager, 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 and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with 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 were having regular health checks and were being referred to other services when required.

The GPs told us they led in specialist clinical areas such as diabetes and sexual health and 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 review and discuss new best practice guidelines. For example, we were shown guidelines for treating patients with lung disease

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 patients' age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored and this information 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 from data entered onto IT system was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us 15 clinical audits that had been undertaken in the last 12 months. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit was carried out to assess the effectiveness of monitoring of patients renal function who received anti-coagulants (blood thinning medicines). An initial audit was carried out in June 2014 found that 60% of patients had their renal function monitored. Measures were put in place to identify and recall the remaining 40% of patients and a second audit was carried in November 2014. The results of this audit showed that 100% of patients on blood thinning medicines had their renal function monitored effectively.

Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

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 analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs

Good

Are services effective?

(for example, treatment is effective)

carried out reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it 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.

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 98.7% of the total QOF target in 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 were similar to the national average.
- The dementia diagnosis rate was comparable to the national average..

The practice's prescribing rates were generally similar to national figures and the practice was aware of all the areas where performance was not in line with national figures. For example, certain types of antibiotic prescribing was higher than national average. We were told that these were prescribed to older frail patients to ensure infections were cleared first time to avoid a second course of treatment.

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 practice had made use of the gold standards framework for end of life care. It had a palliative care register and had monthly 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 most 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 an additional diploma in diabetes care, another in dementia care.

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. Our interviews with nursing staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, a nurse undertook yellow fever training and another undertook dementia diagnosis and management training.

We saw evidence of continuing professional development for the lead nurse practitioner. We were told that formal clinical supervision was not undertaken by their superiors. This was confirmed by the partner GP we spoke with. Dispensary staff had all completed appropriate initial training, but were not aware of medicines related continuing professional development opportunities available to professionally registered staff.

Working with colleagues and other services

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

Good

Are services effective?

(for example, treatment is effective)

Emergency hospital admission rates for the practice were low at 7.35% compared to the national average of 13.6%. The practice held multidisciplinary team meetings to discuss patients with complex care needs. For example, palliative care meetings were attended by GPs, district nurses and palliate care nurses to discuss patients' end of life care needs. 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 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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice had also signed up to the electronic summary care record. Summary care records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours.

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

The practice offered all its patients the opportunity to book their 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.

Consent to care and treatment

We found that most staff were aware of the Mental Capacity Act 2005and their duties in fulfilling it. The GPs and nurse practitioner 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 used a template to assess a patient's mental capacity to make decisions about their care. For example, when making do not attempt resuscitation orders and assessment of Gillick Competence. All clinical staff demonstrated a clear understanding of the Gillick competency test. This is 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.

GPs and staff explained the discussions that took place with patients, to help ensure they had an understanding of their treatment options. We reviewed data from the national patient survey published in January 2015 which showed the practice was rated above both the local and national patient satisfaction average for consent. Of the patients who responded to this survey, 78% said the GP involved them in decisions about their care and treatment compared to the CCG average of 76% and national average of 75%.

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. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We were shown an audit that confirmed the consent process for minor surgery had being followed in 100% of cases. 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.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

Good

Are services effective?

(for example, treatment is effective)

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.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 51% of those patients invited took up the offer of the health check. We were told that any patient who had a risk identified would be referred to a GP for a follow up appointment.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 97% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months was in line with the CCG area. Similar mechanisms of identifying at risk groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. Support for obese patients included invitation to join the NHS Live Well programme and referral to weight loss support groups.

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 vaccination and immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 75.6%, and at risk groups 54.8%. These were above national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 95.1% to 99% and five year olds from 92.8% to 99%. These were both above the local clinical commissioning group average.

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, published in January 2015 and a survey of 135 patients undertaken by the practice.

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 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 91% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 88% and national average of 87%.
- 92% said the GP gave them enough time compared to the CCG average of 86% and national average of 85%.
- 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 92%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 46 completed cards and all 46 were positive about the service patients experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They also said staff treated them with dignity and respect.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

The waiting room and reception desk were situated in the same area of the practice. Staff were aware of the need for privacy and spoke quietly to patients. We asked 32 patients how they felt about this and 25 said they didn't mind being overheard, three said they couldn't be overheard, two said they were not happy to be overheard and two didn't know. The practice switchboard was located away from the reception desk which helped keep patient information private. The practice played music next to the reception desk which helped to prevent patients overhearing potentially private conversations between patients and reception staff. Additionally, 88% of patients said they found the receptionists at the practice helpful compared to the CCG average of 88% and national average of 87%.

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.

There was a clearly visible notice in the patient reception area and in the waiting area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that they had never had to refer patients to this.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed from the same GP survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and rated the practice well in these areas. For example:

- 89% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 74% and national average of 82%.
- 87% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 77% and national average of 77%.

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.

Patients were made aware of the options, services and other support available to them. We spoke with staff who confirmed that discussions took place about these options which enabled patients to make informed choices. Information was given verbally, via leaflets, printed by the GP and from the practice website.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The patient 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:

- 86% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 78%.
- 88% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 78% and national average of 78%.

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. One patient commented about the care the GPs gave a member of their family who was also a carer.

GPs had their own patient lists which meant they had a closer relationship with patients. We were told this arrangement worked particularly well especially in times of crisis. One patient told us about the support a GP gave to their relative who was at the end of their life. The GP gave the family their personal mobile phone number and attended to the dying patient out of hours on more than one occasion.

Notices in the patient waiting room and patient website 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. Information included a Bereavement Support Group, Survivors of Bereavement Support Group and Hampshire County Council Bereavement Support.

Staff told us that if families suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation, a home visit and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, GPs visited terminally ill patients at the weekend and home visits were made by practice nurses during the snow to stop patients being at risk of falls whilst visiting the practice.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. A GP partner told us they were a member of the local prescribing group for the CCG and used this opportunity to share best practice and improve services locally.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the virtual patient participation group. Two changes made included extending dispensary opening hours and introducing an evening surgery.

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. Training records supplied to us before our visit showed that 19 of the 28 staff had received equality and diversity training.

The premises and services had been designed to meet the needs of disabled patients. The whole practice was accessible to patients with mobility difficulties as facilities were all on one level. We saw wheelchair accessible 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 provided a wheelchair for patients who found it difficult to manoeuvre around the practice. There were male and female GPs in the practice; therefore patients could choose to see a male or female GP.

Access to the service

Appointments were available between 8am and 6.30pm on weekdays. The practice also held evening surgeries on Mondays and Tuesdays between 6.30pm and 8.00pm for pre-booked appointments. The practice's extended opening hours on these days was particularly useful to patients with work commitments and older patients who were taken to the practice by working relatives.

The practice offered different types of appointments which included routine appointments that could be booked up to four weeks ahead with the patients named GP. Urgent same day appointments were also available and a minor injury service was also available every day. If a patient wished to speak to a GP without attending the practice they could book a telephone consultation with a GP.

Repeat prescriptions could be requested on-line, via the community pharmacy, in person, by post or fax. Patients with access difficulties could also request their repeat prescription by telephone.

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.

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Weekly visits were made to a local care home by a named GP.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 91% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 76%.
- 97% described their experience of making an appointment as good compared to the CCG average of 80% and national average of 74%.
- 64% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 69%.
- 94% said they could get through easily to the practice by phone compared to the CCG average of 60% and national average of 72%.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy had been reviewed in April 2015 and was in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled complaints in the practice. How to complain information was available on the practice website, in the practice leaflet and on request in reception. We asked 32 patients if they knew how to make a complaint if they felt the need to do so, 25 said they did, five said they didn't know and two were not sure.

We were shown a spread sheet which contained details of 10 complaints received by the practice in the past 12 months. We were told that full details of complaints and resulting investigations were kept separately. We reviewed the complaints folder that contained details of all complaints raised and found they had been dealt with appropriately, investigated and the complaint responded to in a timely manner. Staff reported that complaints which were relevant to them were relayed either at the practice meetings or via individual feedback if this was appropriate.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

For example, a complaint was received about staff providing a patient with incorrect advice regarding their eligibility for a flu vaccination. As a learning point, following resolution of the complaint, staff were reminded that any patient who did not obviously fulfil the requirements for a vaccination, should be referred to the nurses or GP for confirmation.

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. We saw the practice values were clearly displayed on the practice website and in its patient leaflet. The practice vision and values included maintaining good continuity of care by offering a professional service by a named GP.

We spoke with five 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. The practice held away days in January and May 2015 which resulted in a business plan being drawn up. It looked at the next five years and the challenges ahead which included the plan to recruit a new GP.

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. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

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 GP was the lead for safeguarding. We spoke with five 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.

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 (QOF) 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. 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 manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The GP partners in the practice were visible in the practice and staff told us they were approachable and always took the time to listen. All staff were involved in discussions about how to run the practice and how to develop the practice and the GP partners encouraged them to identify opportunities to improve the service delivered by the practice.

Staff said they felt respected, valued and supported, particularly by the partners in the practice. We saw from minutes that team meetings were held bi-monthly. 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. Dispensary staff however told us they felt isolated due to the security protocols of the dispensary but were invited to and attended staff meetings.

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 virtual patient participation group (PPG), surveys and complaints received. The practice's virtual PPG was made up of 135 patients.

The practice carried out a survey of the virtual PPG in 2014 and results were positive. Changes made as a result of feedback included increasing the opening hours of the

Are services well-led?

Good

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

dispensary and promotion of existing on-line services to make patients aware of what was available The results and actions agreed from these surveys were available on the practice website.

The practice had also gathered feedback from staff through staff away days and 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. Most 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

Most staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five 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. This was not the case for dispensary staff who had all completed appropriate initial training, but were not aware of medicines related continuing professional development opportunities available to professionally registered staff.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, dispensary staff raised a concern that the temperature in the dispensary was higher than normal despite NHS property services lagging new pipes. Evidence showed that the temperature was too high and was putting patients at risk from potentially ineffective medicines. As a result the practice installed air conditioning.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment We found people who used the service and others were not protected against the risk of unsafe care and treatment. There were insufficient systems in place to ensure out of date medicines were identified and disposed of, nor appropriate records were kept of Controlled Drugs and medicines related stationary. This was in breach of regulation 12(1), 12(2)(g) Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe Care and Treatment.