Park and St Francis 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 Park and St Francis Surgery on 13 November 2014. During the inspection we gathered information from a variety of sources. For example; we will spoke with patients, members of the patient participation group, interviewed staff of all levels and checked that the right systems and processes were in place.

Overall the practice is rated as good. This is because we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people, people whose circumstances make them vulnerable and people experiencing poor mental health.

Our key findings 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.
- People's needs were assessed and care was planned and delivered in line with current legislation. Staff had received training appropriate to their roles and any further training needs have been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.
- Some patients commented on the long waiting times for routine appointments with their preferred GP. They confirmed that they could see a doctor on the same day if they needed. Patients in urgent need of treatment were triaged by the practice nurse and were offered a same day appointment if medically necessary. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Summary of findings

- 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. The patient participation group (PPG) was active.

We saw several areas of outstanding practice including:

- Research projects carried out by the practice had resulted in improved outcomes for patients. A mental health study ensured that patients with a diagnosis of depression received additional health screening.
- Patients suffering from poor mental health had benefitted from increased access to trained counsellors. This had resulted in a reduction in required GP appointments.
- GPs referred patients, with their consent to the patient participation group (PPG). A member of the PPG made contact and supported the patient to access the help they needed.
- GP partners took dedicated time as a team, away from the practice, to discuss ways of making improvements to the practice. Common themes in the comments from patients had been discussed and acted upon.

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 people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both NICE guidelines and other locally agreed guidelines. We also saw evidence of relevant research and staff training that positively influenced and improved practice and outcomes for patients. Data showed that the practice was performing well when compared to neighbouring practices in the clinical commission group (CCG). The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

This practice was a level two research practice which meant that they conducted at least 10 clinical studies each year. As part of this programme of research the practice employed a research nurse to assist the GPs in this work. GP partners decided if a proposed study was ethically sound and would improve patient care. The practice believed that by taking part in the research projects their patients benefitted from a closer review of their care and treatment.

The practice had developed an intranet system, this gave GPs and nurses access to short focused information that they could retrieve quickly to pass to their patients. This included health promotion, information, self-help techniques and signposting to other relevant organisations.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice highly 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 to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Summary of findings

GPs referred patients, with their consent to the patient participation group (PPG). A member of the PPG made contact and supported the patient to access the help they needed. Most referrals were for older patients who needed signposting to local care or support to avoid isolation, for example accessing transport or community groups.

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 Local Area Team and clinical commissioning group to secure improvements to services where these were identified. Patients said they understood the system for making appointments and were able to get an urgent same day appointment when it was necessary, although to get a routine appointment with a named GP often took a number of weeks.

The practice had good facilities and was well equipped to treat patients to 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 with evidence of staff learning from complaints.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety as its top priority. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.

The practice carried out proactive workforce planning, staff meeting minutes showed that leave planning for GPs was discussed and organised well in advance of proposed GP absences. The GPs and practice manager were aware of the steady rise in patient numbers resulting in the increased demand for patient consultations. We saw plans that had been agreed at a recent management day to increase nurse hours and extra GP sessions to meet patients' needs and expectations.

There was a high level of staff support and training with a high level of staff satisfaction. The practice gathered feedback from patients and worked closely with their very active patient participation group (PPG). Practice GPs and staff gave presentations at PPG meetings to educate and inform patients.

There was a clear leadership structure with named members of staff in lead roles. Each GP partner had a lead role for each area of the Quality and Outcomes Framework (QOF) such as obesity, dementia,

Summary of findings

diabetes and mental health. Each GP partner also had responsibility for a specific subject in relation to the running of the practice such as finance, significant events, new patient registration and patient participation.

The practice had developed an apprenticeship model for the training of newly qualified (foundation doctors) and GP registrars. New doctors started in reception progressing to working with nurses then with triage nurses, the duty doctor and then to routine patient care. This ensured that patients were being seen by doctors who had and developed the skills needed for their role through a planned programme of learning to understand all aspects of patient care.

Summary of findings

What people who use the service say

We spoke with 19 patients on the day of our inspection. We reviewed 24 comment cards which had been completed by patients in the two weeks leading up to our inspection.

We spoke with patients from a number of population groups. These included mothers and children, people of working age, people with long term conditions, people with a diagnosis of poor mental health and people aged over 75 years of age.

Patients were generally complimentary about the practice staff who they said were friendly, polite and respectful. All the patients we spoke with praised the caring and professional GPs and nurses and their ability to respond to both young and older patients' needs promptly. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines, they told us that they didn't feel rushed.

Patients understood the practice's appointment system and were satisfied that they could get an urgent appointment if it was necessary. There was a triage system in operation at the practice; patients were able to call for advice or for a practice nurse to assess them if a same day appointment was required. Most of the patients we spoke with had used this option. We had mixed comments with some patients commenting positively on the caring attitude of triage staff and that they felt happy with the service they received. However two of the people we spoke with felt that the triage system and some reception staff were a bar to them getting a same day appointment even though the patient considered it necessary.

Comments posted on the NHS choices website were mainly positive about the care and treatment patients received from the GPs and nurses however some patients had commented negatively on the availability of appointments. There had been 285 responses to the patient survey that the practice had conducted in January 2014. This survey showed that over 85% of the patients who responded felt staff were considerate and helpful. The 2013 National Patient Survey results showed that 87.7% of the respondents described the overall experience of the practice as good or very good and 81.6% would recommend the practice.

Outstanding practice

- Research projects carried out by the practice had resulted in improved outcomes for patients. A mental health study ensured that patients with a diagnosis of depression received additional health screening.
- Patients suffering from poor mental health had benefitted from increased access to trained counsellors. This had resulted in a reduction in required GP appointments.
- GPs referred patients, with their consent to the patient participation group (PPG). A member of the PPG made contact and supported the patient to access the help they needed.
- GP partners took dedicated time as a team, away from the practice, to discuss ways of making improvements to the practice. Common themes in the comments from patients had been discussed and acted upon

Park and St Francis 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, a specialist advisor in practice management and an Expert by Experience. Experts by Experience are members of the inspection team who have experienced care or treatment from a similar service.

Background to Park and St Francis Surgery

Park and St Francis Surgery have two branches. The main surgery is St Francis Surgery located in Pilgrims Close, Valley Park, Chandlers Ford, Eastleigh Hampshire SO53 4ST and Park Surgery, Hursley Road, Chandlers Ford, Hampshire, SO53 2ZH, approximately two miles away. We did not inspect the service offered from the branch Park Surgery in Hursley Road.

The practice is operated from purpose built premises which are owned by the GP partners. The practice building has seven consulting rooms and two treatment rooms. There is space for allied clinical services to use the consulting rooms. On occasions other health care professionals use the premises.

The practice does not provide an Out of Hours service for their patients. Outside normal surgery hours patients are able to access urgent care from an alternative Out of Hours provider.

The practice provides a range of primary medical services to approximately 15,000 patients. Patients are supported by, four male and four female, GP partners. Further support is provided by a practice manager, seven practice nurses, two health care assistants and administrative and reception staff. The practice is a training practice and has a two GP registrars working at the practice. (A GP registrar has completed their medical training to be a doctor but needs to complete another year in primary care to specialise as a GP).The practice is a member of the West Hampshire Clinical Commissioning Group (CCG).

Park and St Francis Surgery have a General Medical Services (GMS) contract. The GMS contract is the contract between general practices and NHS England for delivering primary care services to local communities.

West Hampshire CCG covers a significantly less deprived area than the average for England. Park and St Francis Surgery covers an area equal to the least deprived 10% of England.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as; the NHS England, Healthwatch, West Hampshire Clinical Commissioning Group (CCG), to share what they knew.

We carried out an announced visit on 13 November 2014. During our visit we spoke with a range of staff including GPs, practice nursing staff, the practice manager and reception and administrative staff. We spoke with patients who used the service. We observed how people were being cared for and reviewed some of the practice's policies and procedures. We also reviewed 24 comment cards where patients and members of the public had shared their views and experiences of the service.

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

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

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

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

Park and St Francis Surgery have a high percentage of their patients in the 35 to 70 age group compared with the average for England. The percentage of patients between the ages of five and 18 registered with this practice is higher than the average for England.

Good

Are services safe?

Our findings

Safe track record

The practice used information gathered both externally and internally to identify risks and improve quality in relation to patient safety. For example, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Potential safety incidents had been acted on promptly and cascaded to practice staff to mitigate future risks. All the staff we spoke with demonstrated an understanding of their responsibilities to raise concerns, and how to report incidents and near misses. For example, a safeguarding concern or an issue relating to patient treatment

A programme of regular meetings, partners' meetings, significant events analysis and virtual ward meetings were used to highlight and discuss any patient safety or medical alerts to ensure verbal and written information was passed to appropriate staff, GPs and nurses. There was a system in place to ensure that medicine alerts received from external bodies such as the Medicines and Healthcare Regulatory Agency (MHRA) were shared appropriately with staff and a record was kept to show that the GP or nurse had seen them. Information also included reported incidents as well as comments and complaints received from patients.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Records were kept of significant events that had occurred and a record of the last 12 months was made available to us. A slot for significant events and complaints was on the partners' weekly meeting agenda; this provided them with the opportunity to discuss any incident and to record any actions. There were also a dedicated meeting every three months to review actions from past significant events and complaints. Records confirmed that appropriate learning had taken place and that the findings were disseminated to relevant staff. For example, following deterioration in a patient's health a system of checks had been put in place and procedures for following up patients who did not attend for hospital appointments. This was to ensure that important consultations were not missed in the future. Staff, including receptionists, administrators and nursing staff were aware of the system for raising issues to be considered at the meetings and felt encouraged to do so.

Incident and complaint forms once completed were dealt with by the practice manager who showed us the system they used to oversee and ensure these were managed and monitored. We saw that incidents and complaints were dealt with in a comprehensive and timely manner. One of the GP partners was the lead for complaints and was consulted as necessary by the practice manger. There was evidence of action taken as a result, for example the practice had changed the way in which they communicated test results to patients to ensure accurate information for all results was given.

Reliable safety systems and processes including safeguarding

The practice had a dedicated GP appointed as lead in safeguarding vulnerable adults and children and they had the necessary training to level three to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak to in the practice if they had a safeguarding concern. Staff were aware of the importance of protecting vulnerable adults and children from abuse and knew how to recognise the various signs and symptoms and how to contact the relevant agencies. All GPs had their own laminated card with the relevant contact details and the same information was displayed in consultation rooms, along with guidance to decide on the action to take. Training records showed that all staff had received training in safeguarding children and adults in March 2014.

A chaperone policy was in place and posters advertising this were seen in the patient waiting room, consulting rooms and treatment rooms (a chaperone is a person who accompanies a patient to protect them and clinicians from inappropriate interactions whilst having an examination). Practice nursing staff and health care assistants acted as formal chaperones.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic software system for primary healthcare which collated all communications about the patient including scanned copies of communications from hospitals.

Good

Are services safe?

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as social services.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice nurses monitored the cold chain (a cold chain is the system for storing vaccines and medicines within the safe temperature range of between two and eight degrees Celsius). We saw records which confirmed checks on temperatures of the fridges were made. Nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance.

Emergency medicines for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location. These medicines were found to be available and within their use by dates. These were checked monthly with the checks recorded electronically. Expired and unwanted medicines were disposed of in line with waste regulations.

Patients were able to request repeat prescriptions at the practice, by post or online, patients told us they did not have any concerns about the process. The practice had a protocol for repeat prescribing which was in line with General Medical Council (GMC) guidance. This covered how changes to patients' repeat medications were managed and the system for reviewing patients' repeat medications to ensure the medication was still safe and necessary. Staff explained how the repeat prescribing system was operated. For example, how certain repeat medications were always checked with the GP before being printed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. Blank prescriptions were stored securely with a system of recording serial numbers.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept, which included a cleaning monitoring sheet in each room. We saw evidence that the senior practice nurse, who was the lead for infection prevention and control (IPC), was in regular communication with the cleaning company employed by the practice to ensure standards of cleanliness were maintained. There had been a recent meeting to address cleaning issues highlighted following an audit of infection control. We saw that these had been acted upon. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

The senior nurse was supported in their role by a GP partner. They had undertaken further training to enable them to provide advice on the practice's infection control procedures. We saw from study leave records that nurses had attended training in infection control within the last 12 months. However it had been identified at the audit, commissioned from an external IPC expert in September 2014 that all staff should receive IPC training during their induction followed by yearly updates. At the time of our inspection training had been arranged but not completed for all staff.

We saw that the lead had carried out regular audits twice each year. GPs were involved in looking at and auditing the cleanliness and procedures carried out in their own rooms. We saw that staff had been updated by the lead for IPC on the results of the most recent audit and the subsequent action plan. We found that most actions had been completed quickly.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to carry out effective infection control. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff. The policy had been updated in October 2014 to include a safe procedure for the urine dipping procedure.

Good

Are services safe?

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

The practice did not have a policy for the management, testing and investigation of Legionella (a bacterium found in the environment which can contaminate water systems in buildings). This had been identified for action and we saw the record of this. The practice had put in place a system of flushing little used water outlets to minimise any risk and had arranged for a Legionella risk assessment.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. We saw that medical equipment had been calibrated. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks via the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting staff to the practice to ensure the person was of good character and had the required qualifications or skills. We saw that risk assessments had been completed for staff as to whether a DBS check was required for their role.

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 system in place for the different staffing groups to ensure there were enough staff on duty. A member of staff was responsible for the monitoring and organising of all staff rotas. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave and the practice could draw on the services of bank staff if necessary. The practice had a locum GP in the role of duty doctor. We saw meetings of staff meetings where leave planning for GPs was discussed and organised well in advance of proposed GP absences.

The GPs and practice manager were aware of the steady rise in patient numbers resulting in the increased demand for patient consultations. They told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice manager was able to show us the plans that had been agreed at a recent management day that included increasing nurse hours and extra GP sessions to meet patients' needs and expectations.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment and emergency alarms. Fire wardens had been appointed and trained, extinguishers were checked annually and weekly alarm tests were recorded. Staff training records showed that staff had received training in fire safety in July 2013 and were waiting for their yearly update.

There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record. The practice had at the time of our inspection written 240 avoidance admission plans for those patients most at risk. Alerts were also attached to the records of vulnerable families.

We saw that staff were able to identify and respond to changing risks to patients such as deteriorating health and well-being. The practice held monthly multi-disciplinary meetings, weekly partners' meetings and clinical meetings each day where patient needs were discussed.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records to show that all staff had received training in resuscitation. All staff when asked knew the location of the automatic external defibrillator (AED) (a machine which is used in the emergency treatment of a patient suffering a cardiac arrest), oxygen, and emergency medicines. We were told that emergency equipment was also available at the branch surgery including an AED.

Good

Are services safe?

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. Processes were in place to check emergency medicines were within their expiry date and suitable for use.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The practice carried out a risk assessment and had established relationships with local contractors to provide urgent maintenance to minimise the risk of a disruption to the service for patients.

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 found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

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

We looked at the data available from the local CCG of the practice's performance for a number of outcomes, all were comparable to similar practices. The practice had a research nurse who had completed a project to recall those patients with mental health difficulties to come into the practice for a physical health check or to complete a blood pressure check which could be passed to the GP. The practice also carried out an annual records review of those patients who had not attended the practice or had a blood pressure check in the previous five years. These patients were called in for a review of their health needs. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital.

There was a system in place to ensure that each GP had an allocated colleague who viewed all their correspondence including test results on days they were not in the practice.

Patients who relied on long term medication were regularly assessed and their medication needs reviewed. There were systems in place to ensure that the GPs reviewed the diagnostic and blood test results of their patients. If a GP requested a diagnostic test such as a blood test the results would be returned to them electronically.

The practice ran a number of specialised clinics to meet the needs of patients. These included asthma and chronic obstructive pulmonary disease (COPD) clinics and a diabetic clinic run by a practice nurse who had specialist training in diabetic care. The practice nurse was aware that the number of diabetics registered at the practice was lower than the national average but that the number had grown considerably over recent years. There was a recall register for patients with diabetes which ensured they had a formal yearly review. The practice nurse was in contact with many patients by telephone to provide help and advice. The practice had established links with the West Hampshire community diabetes team and was able to email a consultant in diabetes for advice on the treatment of their patients. Patients newly diagnosed as diabetics were identified by the practice to ensure they received related health checks, which were carried out by the practice nurse with support from the GPs. The practice provided them with information from national support organisations and followed NICE guidelines to provide them with a structured education programme to promote self-management of their condition.

The practice was aware of the top 2% of their patients at most risk of frequent hospital admission. Care plans had been produced for each of these patients.

Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice routinely collected information about patients' care and outcomes. The practice undertook regular clinical audits and the Quality and Outcomes Framework (QOF) was used to assess the practice's performance (QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries).

The practice regularly reviewed their achievements against the QOF. The practice manager was a regular attender at locality practice meetings where representatives from

Good

Are services effective?

(for example, treatment is effective)

neighbouring practices met to discuss ways of improving outcomes for their patients. The practice also used the information they collected for the QOF and their performance against national screening programmes to monitor outcomes for patients. For example, the percentage of patients with diabetes who had received a foot examination in the previous 12 months was higher than the national average figure for England. This practice was not an outlier for any QOF clinical targets.

The practice has a system in place for completing clinical audit cycles. We saw evidence of complete clinical audit cycles, one of which showed the practice had audited patients who had a history of Transient Ischemic Attack (TIA) or ischaemic stroke to ensure that the safe prescribing of medicines for these patients had been reviewed and followed current best practice guidelines. . The practice had carried out other audits to improve patient care for example two week wait referrals, for urgent suspected cancer referrals to hospital, to assess the appropriate use and outcomes of this type of referral.

This practice was a level two research practice which meant that they conducted at least 10 clinical studies each year. As part of this programme of research the practice had employed a research nurse to assist the GPs in this work. The lead GP for research, in consultation with the GP partners decided if a proposed study was ethically sound and would improve patient care. The practice believed that by taking part in the research projects their patients benefitted from a closer review of their care and treatment.

Recent and current research programmes included monitoring the side effects and benefits of a nasal flu vaccine. A study to show if cognitive behaviour therapy had a positive effect on irritable bowel syndrome and a mental health study to ensure that patients with a diagnosis of depression received additional health screening. Patients suffering from poor mental health had benefitted from one of the research projects which had resulted in over 400 extra hours of counselling being available over the past 12 months. They set up a low cost 6 session model for problem solving counselling. The model enabled trainee counsellors to gain experience within a supported setting, supervised by an experienced counsellor funded by the practice. The project resulted in a reduction in required GP appointments and an improvement of the well-being of patients identified by the counsellors and GPs. This project was submitted to the National Institute of Care Excellence NICE and is available on their website.

Effective staffing

All the staff we spoke with, the GP registrar, nurses and those in administrative roles told us they were well supported by the GPs and the practice manager. There was an induction programme for newly recruited staff. All staff as part of their induction followed programme to ensure they were aware of their roles and responsibilities and practice procedures. A personal training plan was recorded at the end of induction review meeting.

There was an annual appraisal system in place for staff. Staff we spoke with confirmed they had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they may have, around patient care or practice management, and their own personal development. Staff told us the practice organised staff training in a number of areas and supported staff to attend relevant training. The practice manager told us that wherever possible they organised face to face training as a more effective alternative to e learning. Nursing staff had taken part in a range of training courses to improve patient care such as diabetes, flu and travel vaccine updates and wound dressing. All practice staff had received training in basic life support, information governance and child and adult protection. GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Council (GMC). One of the GPs at the practice was a GP appraiser.

During our inspection we spoke with 19 patients and reviewed 24 comment cards. Most commented positively on the availability of urgent appointments however there were some concerns raised about the wait for routine appointments. This had been identified by the practice and patients were informed on the practice website. Plans were in place to increase staffing levels; we found there was sufficient staff available to meet patients' urgent needs.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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

Good

Are services effective?

(for example, treatment is effective)

responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice worked with others to improve the service and care of their patients. There were arrangements in place for other health professionals to use the practice premises to provide services to patients, such as midwives and counsellors, the premises were shared with a dental practice. Antenatal and postnatal care was provided by midwives based at the practice and health visitors.

The practice held monthly virtual ward meetings to which other health care professionals were invited to attend when appropriate. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information and ensuring best treatment outcomes for patients.

The practice was working with neighbouring practices within the West Hampshire CCG using funds from the transformation fund to create locality hubs. The practices were working together to increase access for patients to services such as phlebotomy (taking blood for testing). Patients would be able to visit any of the participating practices to access these services.

Information sharing

The practice used several methods communicate with other providers. For example, there was a shared system with the local out of hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system if required. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital).

Patient information was stored securely on the practice's electronic record system. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice had historic paper patient records which were used if necessary to review medical histories.The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life was being managed at their home.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes. The practice arranged double appointments for patients who needed support to make decisions to allow adequate time which may be needed to help their understanding. GPs gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision.

GPs we spoke with demonstrated a clear understanding of Gillick competencies, to identify children aged less than 16 years of age who have the capacity to consent to medical examination and treatment and were familiar with using the assessment. GPs advised young people about parental access to their electronic prescribing record. Whilst they encouraged under 16s to share information with their parents they acknowledged that children of that age were able to give or withhold consent and the practice would not disclose information to parents without the consent of their young patients.

There was a practice policy for documenting consent for specific interventions. For example, written consent was obtained for all minor surgery and some family planning procedures. For other interventions a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice had a range of health promotion leaflets in their waiting rooms and other areas. Noticeboards were used to signpost patients to relevant support organisations such as day care, physiotherapy and counselling. Practice nurses had specialist training and skills, for example in the treatment of asthma, diabetes and travel vaccinations. The practice offered a full travel vaccination service including yellow fever. This enabled nurses to advise patients about the management of their own health in these specialist areas.

One of the GPs had developed a computer system for use in the practice. Built up over 15 years this gave short focused information that GPs and nurses could retrieve quickly to give to their patients. This included health promotion, information, self-help techniques and signposting to other relevant organisations.

The practice offered NHS Health Checks to patients in specific age groups. These were carried out by the practice nurses who would discuss the findings with patients and refer to a GP if a medical opinion or diagnosis was required.

The practice offered a full range of immunisations for children and data showed that the practice had vaccinated a high percentage of eligible children. The practice offered flu vaccinations in line with current national guidance. The provider offered home visits to give flu vaccinations for eligible patients who were housebound.

The practice had a large active patient participation group (PPG) who met regularly and also organised open meetings to which all patients were invited. These meetings took the form of information and education meetings. At a recent meeting one of the practice nurses had spoken about holiday health.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

During our inspection we spoke with 19 patients, reviewed 24 comment cards and spoke with a representative of the patient participation group (PPG). The majority of patients were complementary about the care that they, or the patients they represented, received from all the practice staff. We spoke with patients of varying ages who said that they had been dealt with courteously by all staff. We observed staff interacting with patients and we saw that patients were treated with dignity and respect.

We reviewed the most recent data available for the practice on patient satisfaction. This included their own satisfaction survey, information from the NHS England GP patient survey and NHS Choices. The evidence showed patients were satisfied with how they were treated and that staff were considerate and helpful.

Staff told us how they respected patients' confidentiality and privacy. All telephone calls were answered by staff in a closed office behind the reception desk which ensured that confidential information could not be overheard. We saw this in operation during our inspection and noted that it was effective in maintaining confidentiality. There was a private area available for patients beside the reception area where private conversations could take place. All staff had taken part in information governance training and those we asked were able to demonstrate how they ensured patients privacy and confidentiality was maintained.

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.

Care planning and involvement in decisions about care and treatment

Patients told us that their GP explained their treatment and all commented that there was enough time to discuss their needs. They also told us they felt listened to and supported by staff. They understood what had been said in order to make an informed decision about the choice of treatment they wished to receive. The comment cards we received were also positive and praised the caring, helpful attitude of staff.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with were positive about the emotional support provided by the practice. For example one patient told us that following bereavement their GP provided excellent care and emotional support.

The patient participation group (PPG) provided a service to patients by signposting them to local support services. With consent, GPs referred patients to the PPG. A member of the PPG made contact and supported the patient to access the help they needed. The chairperson of the PPG told us that most referrals were for older patients who needed signposting to local care or support to avoid isolation, for example accessing transport or community groups.

Notices in the patient waiting room told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Patients had been put in touch via members of the PPG to a local carers' information morning. A member of the PPG represented the practice at the 'Valley Park Network' whose aim was to identify the services and activities available locally. The PPG representative was able to inform the network about the work of the practice.

The practice met regularly with the community care team, the local hospice and the palliative care team to ensure all professionals are aware of end of life wishes. GPs told us that they involved families and carers in end of life care and worked to provide help and support for those patients at the end of life.

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs and ensured they received specific patient notes. This included individualised information about patient's complex health, social care or end of life needs.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The practice had developed an appointment system to ensure that any person who needed advice about their health or to see a GP or nurse was able to do so the same day.

The practice worked collaboratively with West Hampshire Clinical Commissioning Group (CCG) and other practices to discuss local needs and service improvements that needed to be prioritised. For example establishing locality hubs to provide greater access for patients for services such as phlebotomy (taking blood for analysis).

The practice had a patient participation group (PPG). The practice's patient feedback survey had been designed based on issues raised by the group. The PPG had been consulted about the questions for the annual patient survey carried out in January 2014. Most of the questions for that survey were aimed at gaining patients' opinions on the appointment system and access to appointments. Following the survey the PPG had agreed a plan of action with the practice for changes in response to the outcome of the survey. This included providing up-to-date information if a GP or nurse was running late and giving patients information about appointment availability on the practice website. We saw that the actions had been implemented for example the website kept patients informed about the availability of appointments and the electronic messaging system in the waiting room notified patients if their GP was running late.

One of the GPs and the practice manager attended the PPG meetings. The representative from the PPG told us the practice was very receptive to suggestions made to improve the service to patients. For example the PPG had suggested that if the practice could reduce the number of patients missing their appointments it may help to reduce the wait for routine appointments. The practice had started writing to patients who failed to attend their appointments and had also initiated text reminders for patient appointments.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services, for example patients who had work commitments, those with long term conditions, the elderly including those living in care homes, patients with a learning disability and children under-five.

The practice had provided equality and diversity training for staff which the practice training record confirmed had been completed in the last 12 months. This was a subject considered by the practice to be mandatory for all staff.

The premises were purpose built; we saw that the waiting area was large enough to accommodate patients with wheelchairs and prams. However the premises did not allow for independent access for any patient who used a wheelchair or had mobility issues. There was a manually operated main door to the practice building which we noted was heavy and difficult to open. A patient commented to us that access was difficult for anybody with mobility issues. We saw that this was also an issue raised at the most recent practice satisfaction survey. There was a section of the reception desk at a lower height to provide access for patients unable to use the higher main counters however we found these areas had shutters on them. There were disabled toilet facilities on every floor and a lift available if required.

The practice had a population of mainly English speaking patients however the practice was able to organise telephone or face to face interpretation services for patients whose first language was not English.

Access to the service

The practice could be contacted between 8am and 6.30pm Monday to Friday for enquiries or emergencies. The appointment line was open from 8.15am to noon and from 2pm to 6pm. A range of appointments were available including routine, urgent (same day) and telephone consultations. Patients could book routine appointments with their preferred GP but this was for a number of weeks in advance. A number of appointments were released for booking five days or 48 hours in advance. The practice operated an all-day nurse lead triage system with a duty GP working all day to provide urgent face to face consultations. There was no limit to the number of urgent consultations available if a patient needed to be seen. Practice nurses provided a minor illness clinic each morning and were available all day for routine nurse appointments. There was extended hours opening at the practice's branch surgery for

Good

Are services responsive to people's needs?

(for example, to feedback?)

pre booked routine appointments with the GP and for chronic disease appointments with the practice nurse. The practice branch surgery was open each weekday between the hours of 8am and 12.30pm.

Comprehensive information was available to patients about appointments on the practice website and in the practice booklet. This included how to arrange routine and urgent appointments and home visits. 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. Information about out of hours care was published on the practice website.

Longer appointments were also available for people who needed them and those with long-term conditions. Longer appointments were made for patients with a learning difficulty to ensure they could be treated in a relaxed manner.

Patients were generally satisfied with the appointments system but some commented on the long waiting times for routine appointments with their preferred GP. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had been triaged by the practice nurse and had been offered a same day appointment if it had been medically necessary.

Listening and learning from concerns and complaints

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

Accessible information was provided to help patients understand the complaints system this was set out in the practice leaflet, on the practice website and displayed in the practice.

Evidence seen from reviewing a range of feedback about the service, including complaint information and supporting operational policies for complaints and whistleblowing, showed that the practice responded quickly to issues raised. The record of complaints showed that all complaints had been responded to in a courteous manner by the practice manager. Any comments made about the practice on the NHS Choices website had been responded to by the practice manager, either thanking the patient for their positive comments or encouraging the patient to approach the practice to allow them to address their concerns.

The practice regularly analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback.

There was evidence of shared learning from complaints with staff. We noted from minutes of meetings and by talking with staff that complaints were discussed to ensure all staff were able to learn and contribute to improvements at the practice.

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. Their ethos was to promote an open culture and teamwork where each person played their role. Decisions were made democratically and patient care was frequently shared by GPs.

We spoke with five GPs, a GP registrar, two practice nurses, the practice manager and a number of reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these.

All staff felt able to make suggestions to improve outcomes for patients for example in relation to appointment systems or from personal research or learning. GP and nursing staff used clinical meetings, clinical audit and research activity to share and discuss information to improve effective patient care.

The practice worked with other practices towards providing improved services for their patients. For example by setting up locality hubs to improve access for patients for services such as phlebotomy. Patients described the practice as kind, efficient and friendly.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at a number of these policies and procedures, all the 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. Each GP partner had a lead role for each area of the Quality and Outcomes Framework (QOF) such as obesity, dementia, diabetes and mental health. Each GP partner also had responsibility for a specific subject in relation to the running of the practice such as finance, significant events, new patient registration and patient participation. Staff were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice manager told us that they met regularly with other practice managers from the West Hampshire Clinical Commissioning Group (CCG). This gave the practice the opportunity to measure their service against others and work collaboratively to identify areas for improvement and to identify best practice.

The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. There was also an on going programme of clinical research with the practice being among a group that carries out in excess of 10 research projects each year. These projects were carried out and formally analysed to identify areas where changes to practice would result in improved outcomes to patients.

The practice had robust arrangements for identifying, recording and managing risks. For example we saw staff meeting minutes which recorded the discussions around staffing levels and provision for holiday cover for GPs. The practice had a business continuity plan which had been regularly updated to ensure it identified any possible risks to service disruption. One of the GP partners was the lead for Health and Safety, whilst individual departments were responsible for their own environment the Health and Safety lead was able to assess the overall risks.

Leadership, openness and transparency

There was a plan of regular meetings which took place at the practice. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The leadership was established at the practice as GP partners had been in their roles for a number of years. All the staff we spoke with who told us they felt supported by the practice manager and GPs. They confirmed there was an open culture and felt they could go to any senior staff member with any problems, concerns or ideas. All staff were clear about their roles and responsibilities and they were provided with opportunities for development and training.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example equal opportunities, age discrimination and

Are services well-led?

Good

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

the induction policy, which were in place to support staff. The practice manager was responsible for the day to day running of the service and assessing, monitoring and developing staff whose roles were in reception or administration.

A representative from the patient participation group (PPG) told us that they were able to communicate easily with the practice. There was a GP partner who was responsible for the practice relationship with their PPG. They told us that they could contact them or the practice manager at any time and they attended the majority of PPG meetings.

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

The practice had gathered feedback from patients through their annual satisfaction survey, feedback from their active patient participation group (PPG) and from compliments and complaints. We were told by the PPG that the practice was very responsive to their suggestions and changes had been made to the practice as a result of their feedback. For example the practice had responded to their ideas to reduce missed appointments.

We saw that following the patient satisfaction survey concerns around the lack of privacy for patients using the blood pressure monitor had been addressed. The blood pressure machine was now screened from the rest of the waiting room. We saw evidence of common themes in the comments from patients about the wait for routine appointments. The practice had increased the number of GP consultations available by the increased use of contracted locums. Minutes of a recent away day for the GP partners showed that decisions had been made to increase the amount of practice nurse time and to introduce an extra six GP sessions.

There had been 285 responses in the patient survey which was conducted in January 2014. The survey questions had been developed collaboratively with the PPG and given to patients who visited the practice at that time. Members of the PPG supported the survey by handing out the forms in reception and helping patients to complete the forms if they needed it. Copies were given to GPs, district nurses and midwives to take to home visits. Questions were focused on the appointment system within the practice in order to gauge patients' experiences when accessing appointments. The practice manager showed us the analysis of the survey and the subsequent action plan which had been developed and discussed with the PPG. The results and actions of the survey were available for patients on the practice website.

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 saw that regular appraisals took place and all staff we spoke with confirmed they had taken part in the appraisal process. Staff told us that the practice was very supportive of training and provided regular training or supported them to attend training elsewhere. All staff were able to contribute to staff meetings and to make suggestions for future training.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally as appropriate to ensure the practice improved outcomes for patients. The GP registrar we spoke with told us they were involved in discussions around significant events and concerns and could have further discussions with their trainer (a GP from the practice) as part of their learning.

The practice had also developed and funded a model of counselling education which benefited their patients by supporting counsellor development by providing community based training for counsellors.