The Panton 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?	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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Panton Practice on 7 May 2015. Overall the practice is rated as good. Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, working age and recently retired people, families, children and young people, people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Students and holiday makers were able to register as temporary patients, and could be seen immediately if needed for treatment.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned for.
- The practice was a GP training practice and mentored third year medical students from Southampton University, along with doctors training to be GPs.
- 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 GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice planned and operated it services in a responsive way and considered the needs of all population groups.

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 provider should

- Share learning with all relevant staff on complaints that occur and undertake analysis to identify trends or themes.

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 to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

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

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice 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 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 Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a 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. 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 not routinely shared with staff.

Summary of findings

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. Improvements were needed to share learning with all relevant staff on complaints that occurred and analysis to identify trends or themes. 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. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the

Summary of findings

needs for this age group. A full range of contraception and women's health services were offered by the practice. Students and holiday makers were able to register as temporary patients, and could be seen immediately if needed for treatment.

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 patients of no fixed abode and those with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 93% of people living with dementia had an agreed care plan in their records. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with a total of six patients who used the practice. We did not receive any comments cards on the service provision. Patients we spoke with considered they were treated with respect and their health needs were being met. They said they were involved in discussions about their care and treatment and were provided with sufficient information to make decisions.

Results from the national GP patient survey showed that 81.3% of patients would recommend the practice to others and 81.5% described their overall experience of the GP practice as fairly good or good.

- Results from the National GP patient survey showed that 91% of patients described their overall experience of their GP practice as fairly good or good, compared with the national average of 85.75%.

Other areas where the practice was similar to or above the national average included:

- 93% said the GP was good at listening to them compared to the national average of 88%.
- 84% said the GP gave them enough time compared to national average of 86%.
- 99% said they had confidence and trust in the last GP they saw compared to the national average of 93%

Areas for improvement

Action the service SHOULD take to improve

- Share learning with all relevant staff on complaints that occur and undertake analysis to identify trends or themes.

The Panton Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Panton Practice

The Panton Practice is situated in central Bournemouth and has approximately 12,300 patients registered. The practice additionally cared for approximately 1000 temporary residents during the holiday season and had arrangements in place to ensure these patients were able to access the service.

The practice serves a muti-cultural population which includes foreign language students, and Polish and Jewish families. There are areas of deprivation within the practice catchment area and some of the patient population misuse alcohol and drugs, and there is a prevalence of patients diagnosed with HIV.

The practice staff consists of five partners, two salaried GPs, one GP trainee and three nurses. There are a total of five female GPs and three male GPs. The clinical team is supported by nine receptionists, eight administration staff, a practice manager and a finance manager. The practice holds a general medical services contract.

The practice operates from two locations:

The Panton Practice, 14 Gervis Road, Bournemouth. BH1 3EG and its branch location at St Leonard's Road Surgery, 20 St Leonard's Road, Charminster, Bournemouth. We inspected the main site at Gervis Road.

The practice was open from 8am to 6.30pm Monday to Friday. Routine appointments were available from 8.30am to 10am and 3pm to 5pm on weekdays. Extended hours surgeries were available from 7am to 8am at the St Leonard's Road location on Tuesdays and 6.30pm to 8.15pm at the Gervis Road location. These appointments were pre-bookable. Nurse appointments were available throughout the day and could be booked up to a month in advance. The practice ran a sit and wait clinic at both locations from 10.30am to 11.30am and a duty GP was available between the hours of 8am to 6.30pm. Telephone appointments were offered and these could be routine, where a patient may request to speak with a particular GP, or same day appointments, where patients would speak with the duty GP.

Out of hours patients are directed to the out of hours GP service based at Poole Hospital, which is provided by South Western Ambulance Services via 111.

Why we carried out this inspection

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

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

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Including local NHS England, Healthwatch and the clinical commissioning group. We carried out an announced visit on 7 May 2015 at The Panton Practice. During our visit we spoke with a range of staff which included GPs, nurses and reception staff. We spoke with patients who used the service.

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 and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. 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 significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda. One example of a significant event occurred when a patient was prescribed an antibiotic by the hospital that they were allergic to. The practice provided the prescription and the patient collected the medicine to take and noted that they were allergic to this particular medicine. The patient did not take any of the medicine and alerted the practice and a suitable alternative was prescribed. As a result of this incident the practice changed it prescribing policy to ensure that all new medicine a patient needs were only prescribed by a GP.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and level three child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware of who these leads were and who to speak with in the practice if they had a safeguarding concern. There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks or had been risked assessed. (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).Chaperones were usually nurses. When a receptionist was required to carry out chaperoning duties they had received appropriate training and checks to carry this out.

Medicines management

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Practice staff monitored the refrigerators' temperatures and appropriate actions had been taken when the temperatures were outside the recommended ranges.

The nurses used Patient Group Directions to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw examples of these directives and found they were in date and current.

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Are services safe?

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

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying medicines, which included regular monitoring. Appropriate action was taken based on the results. We looked at prescribing data from the Quality and Outcomes Framework (QOF) and saw the practice was in line or below the national prescribing pattern for antibiotic, hypnotics and anti-inflammatory medicines.

Cleanliness and infection control

We saw that the premises were visibly clean and tidy. Routine cleaning was carried out by contractors and there were systems in place to check on standards of cleanliness. There were comprehensive cleaning schedules in place which detailed how often each area of the practice should be cleaned. Patients said they had no concerns about cleanliness or infection control.

The practice had arrangements in place to manage clinical waste, non-hazardous waste and used needles and medicines which were in line with national guidance and regulations. We saw clinical rooms had colour coded waste bags and sharps containers to ensure waste was appropriately segregated prior to disposal. Where disposable privacy curtains were used these were changed at least every six months, or sooner if needed.

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 and aprons 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 policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

We looked at the policy and found it complied with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance. The practice had nominated infection control leads who linked with the infection control lead for the clinical commissioning group (CCG) for advice and support. Weekly infection control checks were carried out on the cleanliness of equipment such as trolleys, weighing scales and couches. We found that any areas which needed addressing had been actioned.

A full audit of infection control processes within the practice had been carried out and one of the leads was collating the information to produce an action plan and annual statement.

The practice had a policy in place for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). A legionella risk assessment had been completed and legionella testing had been carried out. Testing included weekly monitoring of hot and cold water temperatures and quarterly descaling of shower heads. Records we looked at confirmed this.

Equipment

Staff said they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. We looked at records for equipment testing and calibration. (Calibration is where pieces of equipment such as weighing scales and thermometers are tested to ensure they provide accurate measurements). We found that all equipment was tested and maintained. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was in 2014. There was an annual maintenance schedule in place for equipment such as emergency lighting, alarms systems and servicing of the gas boiler.

Staffing and recruitment

The practice had a recruitment policy that set out its standards when recruiting clinical and non-clinical staff. We saw that a list of checks, that were carried out before a person was employed, included evidence of conduct in previous employment in the form of references, proof of qualifications and registration with the appropriate professional body. The list included completing a criminal records check via the Disclosure and Barring Service (DBS) or a risk assessment to determine why a DBS check was not required. We looked at a total of five staff recruitment files which included those for GPs, nurses and administration staff. We found that all had evidence of satisfactory conduct in previous employment, a full employment history and when needed evidence of criminal records checks carried out via the DBS. The recruitment process was carried out in line with their practice policy. When

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Are services safe?

needed checks with professionals bodies such as the Nursing and Midwifery Council were made to ensure that nurses were registered to practice. The GP performers list was also checked when a new GP was recruited.

The practice manager showed us rotas and timetables they kept to ensure there were sufficient staff on duty. We found there were sufficient numbers of staff available to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. When needed locum GPs were used to cover appointments. A locum GP is a GP who temporarily fulfils the duties of a permanent GP. Arrangements were in place with a buddy system to cover for annual leave or sickness for all staff groups.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the environment to ensure it was hazard free, medicines management, staffing, dealing with emergencies and equipment, for example portable appliance testing. We found that the risk assessments in place were comprehensive and were rated as to the likelihood and potential impact that could occur if issues arose.

There was a health and safety policy in place and all staff we spoke with were aware of the policy.

The practice had met with the local police who provided advice and guidance on dealing with conflict and managing challenging behaviours. There were personal alarms systems on computers and desks to keep staff safe and allow them to summon help if needed. For example, if a patient or visitor was behaving in a threatening manner.

Arrangements to deal with emergencies and major incidents

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

There were suitable arrangements in place to manage the risk of fire. All staff had received training and fire evacuations were carried out twice yearly, the last one occurring in April 2015. A fire risk assessment had been carried out in 2013, actions from this had been completed, but the documentation had not been updated to show it was done.

Emergency medicines were held securely in the practice and all staff knew where this was. The medicines included those used for the treatment of cardiac arrest, abnormal heart rhythms and low blood sugar levels. Processes were in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice's business contingency plan was being reviewed by the practice manager at the time of our visit. We saw that the plan included information about arrangements to use another GP's premises if the practice was out of action. There was also information on procedures to be followed in the event of a power failure or loss of computer systems. The practice manager said that once their review of the plan was completed it would be shared with the team leaders of staff groups.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

GPs and nursing staff were able to clearly outline the rationale for their approaches to assessment and treatment. They were familiar with current best practice guidance, and accessed information from the National Institute for Health and Care Excellence and from local commissioners. GPs said that they used templates which were embedded on their computer systems to assess and treat patients. These templates were in line with national guidance and locally adapted to fit the needs of the patients that were registered with the practice. Examples given included safe prescribing of antibiotics and chronic disease management, such as asthma.

The practice had identified those patients who were deemed to be at high risk of inappropriate hospital admission. These patients had care plans in place which were reviewed regularly with the patient. The care plans set out how to meet their needs to assist in reducing the need for them to go into hospital. If one of these patients was admitted to hospital their GP would review the admission to ensure it was medically appropriate. When needed amendments to care plans were made to ensure that all needs were continuing to be met.

The GPs told us that they lead in specialist clinical areas such as diabetes, sexual health, women's health and heart disease. The practice nurses supported this work and ran nurse led clinics for long term conditions such as respiratory (breathing) conditions.

Management, monitoring and improving outcomes for people

Information from the quality and outcomes framework (QOF), a national performance measurement tool, showed that the practice achieved 95.6% in its QOF results, which was slightly higher than the practice average across England. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was similar to or above the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- The percentage of patients with schizophrenia, bipolar affective disorder and other mental health conditions having an agreed documented care plan was higher than the national average.

The practice had a system in place for completing clinical audit cycles. All GPs had to undertake an audit as part of their appraisal process. Examples of completed clinical audits included ones related to contraceptive implants and coil fittings, to ensure there was no infection or expulsion of the device.

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

GPs carried out minor surgical procedures at the branch location and this was carried out in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and used them in their learning.

Effective staffing

The practice had suitable systems to ensure staff were trained to carry out their roles. All staff had received an annual appraisal and training and development plans were put into place following the appraisal. New employees were subject to regular reviews during their probation period, which allowed learning needs to be identified early on and planned for. The practice manager was collating records of all training received into one computerised record and there was a training programme in place for the forthcoming year. Further training had been provided to develop staff in their roles, for example dementia care workshops, carers' awareness and consent. GPs who had specialist interests had also received training to enable them to carry out their role, for example, coil fittings and family planning. Staff we spoke with confirmed that they received specific training appropriate to their role and were fully involved in the process.

All GPs were up to date with their yearly continuing professional development requirements and all had either been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment

Good

Are services effective?

(for example, treatment is effective)

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).

Working with colleagues and other services

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

The out of hours service (OOH) was able to access summary care records held by the practice. Summary care records consist of important details about a patient, such as known medicine allergies, brief details of their past medical history and whether they had a current care plan in place. The practice sent information to the OOH service via fax and information received from the OOH service was received via email. Regular meetings were held with other health professionals, such as district nurses and health visitors, to discuss patient needs or safeguarding concerns. Patients who were receiving end of life care were discussed at regular meetings with the community care team and risk assessed according to their condition, to make sure effective treatment was provided.

The practice worked with the midwifery team to provide ante and post natal care for pregnant women and new mothers. The practice was able to message the midwifery team with any urgent concerns or GPs would speak with midwives when they were in the building carrying out clinics. The practice also worked with the clinical commissioning group's multidisciplinary team on reduction admissions to hospital and supporting patients in their own homes.

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. The practice computer systems were linked between both locations and summary care records were accessible to relevant care providers. The practice was also able to access on line links with the local hospitals to obtain test results.

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

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. Patient group directives were in place for immunisations and consent was checked at each stage if a course of vaccinations was being given, we saw that this was recorded in the patient record.

Good

Are services effective?

(for example, treatment is effective)

Health promotion and prevention

The practice provided information on health promotion and prevention on its website, in the practice booklet and by way of printed information in the waiting area. There was also a TV screen in the waiting area which had information on health promotion such as weight loss and exercise programme. Patients were able to self-refer to a private physiotherapy service and receive a 12 week discounted programme. The practice offered the full national range of health checks, including new patient checks and participated in the expert patient programme. This programme is designed to help patients with long term conditions to self-mange their health and keep well.

The practice's performance for the cervical screening programme was 73.5%, which was below the national average of 81.89%. The practice was aware of this and was actively promoting uptake during routine appointments. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 68.34%, and at risk groups 41.86%. These were similar to national averages.

Childhood immunisation rates for the vaccinations given to under two year olds ranged from 87.1% to 98.3% and five year olds from 82.1% to 92.7%. These were comparable to national averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015.

The evidence from this 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 at 75% for patients who rated the practice as good or very good. The practice was also comparable to clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with doctors and nurses. For example:

- 88% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 87% said the GP gave them enough time compared to the CCG average of 82% and national average of 80%.
- 91% said they had confidence and trust in the last GP they saw compared to the CCG average of 94% and national average of 92%

Telephone calls were taken away from the reception desk. We saw staff speaking quietly to avoid being overheard. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 81% of patients responding to the survey said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Patients told us that they considered they were treated with respect and their privacy was maintained. They said they were not rushed when they saw a GP or a nurse and had sufficient time to discuss concerns. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

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

- 82% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 82%.
- 76% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 75%.

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.

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

Patient/carer support to cope emotionally with care and treatment

The 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:

- 81% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 78%.
- 78% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 78%.

Information for carers was available in the reception and a member of staff was responsible for coordinating a carer's register and provided support to these patients. The practice's computer system had flags placed on them to indicate whether a patient was a carer or being cared for. This enabled GPs and nurses to ensure they were appropriately supported.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example , patients who were homeless were able to be referred to or signposted to services that could assist them. The practice also worked with the local YMCA to support patients there.

The practice met with the Clinical Commissioning Group (CCG) and engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. Such as, early intervention in psychosis for patients aged 14 to 35, who may be experiencing mental health conditions.

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. Patients who were living with HIV could access a specialist clinic in Bournemouth and the practice was able to access hospital consultant advice for patients with Hepatitis B and C, a blood borne virus. The practice had some patients registered with them who had come to the United Kingdom as a result of 'human trafficking', the practice worked with local hostels to encourage these patients to access health screening and treatment.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. The practice was also able to use a company to translate medical records and results of tests undertaken in different countries. We were given an example where a patient had gone to Poland to have an MRI scan and the practice used the company to translate the results of the scan. This translation service was set up by a group of local GPs and was utilised by other practices in the CCG area. One of the GPs spoke German. When needed a British Sign Language interpreter could be arranged.

The premises and services had been adapted as far as possible to meet the needs of people with disabilities. The practice was accessible to patients with limited mobility. One consulting room was on the first floor and this was used primarily for the midwifery team attached to the practice. The consulting rooms were also accessible for patients with limited mobility and there were access enabled toilets and baby changing facilities. There was a large waiting area with space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. There was a hearing loop installed in the practice for patients who had limited hearing.

Staff told us that they did have patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 8am to 6.30pm Monday to Friday. Routine appointments were available from 8.30am to 10am and 3pm to 5pm on weekdays. Extended hours surgeries were available from 7am to 8am at the St Leonard's Road location on Tuesdays and 6.30pm to 8.15pm at the Gervis Road location. These appointments were pre-bookable. Nurse appointments were available throughout the day and could be booked up to a month in advance. The practice ran a sit and wait clinic at both locations from 10.30am to 11.30am and a duty GP was available between the hours of 8am to 6.30pm. Telephone appointments were offered and these could be routine, where a patient may request to speak with a particular GP, or same day appointments, where patients would speak with the duty GP.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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. All GPs and the majority of nurses worked at both locations and information on which location they would be working at was available in the practice leaflet and on the website.

Longer appointments were also 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.

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

- 62% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 63% described their experience of making an appointment as good compared to the CCG average of 82% and national average of 74%.
- 85% said they could get through easily to the surgery by phone compared to the CCG average of 52% and national average of 72%.

The practice cared for approximately 1000 temporary residents during the holiday season and had arrangements in place to ensure these patients were able to access the service. When needed the practice shared information with the patients usual GP.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system on the practice website and in their practice booklet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at complaints received in the last 12 months and found that complaints were investigated and responded to. However, the response letters did not always include details of other agencies a complainant could take their concerns to if not satisfied with the practice response. For example, Parliamentary Health Service Ombudsman. This information was available in the practice leaflet. We found that GPs responded to clinical concerns and the practice manager responded to non-clinical concerns. We noted that responses were factual in nature, but at times contained language that could be seen as defensive. Learning from complaints was not routinely shared with relevant staff in the practice. The practice did not monitor complaints received to identify trends and ensure measures were put into place to minimise the risk of reoccurrence and ensure complainants were satisfied with the response.

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's statement of purpose set out the vision and values of the practice. These included providing high quality personalised care and a focus on disease prevention and promotion of health living. Another aim was to work effectively with other care providers to deliver integrated care and treatment. The practice told us in their presentation at the start of the inspection that they were aiming to move the premises to a new building and were keeping patients and staff informed of the progress of this venture. We saw there were posters displayed in the waiting area about federating with other practices and moving to a new building. Staff we spoke with were aware of these plans and agreed with the vision and aims of the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a sample of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when.

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 nominated GP was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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. This 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.

Suitable arrangements were in place to protect patient confidentiality and ensure records were kept securely. We saw that paper records were kept in rooms which were locked at the end of each day and when they were vacant. Confidential waste was kept in sealed bags until it was collected for secure destruction. Staff had access to computer systems which were password protected and required a smart card to access.

Leadership, openness and transparency

The partners considered that the practice manager and finance manager were part of the leadership team and trusted them with the organisation of the practice. The practice manager considered they were trusted to fulfil their role. The partners did not meet separately to discuss the business planning for the practice, but included the practice manager and finance manager in these meetings.

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

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

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed, however learning from complaints was not routinely shared with relevant staff members. Complaints received had not been analysed to identify whether there were any trends occurring, which could be mitigated. The practice manager said that the training programme was being reviewed and updated to include these areas and there would be time set aside at meetings to discuss them.

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

The practice had a patient participation group (PPG) which met every two to three months. We met with a representative from this group. They showed us the work they were doing to prepare for the annual patient survey.

Are services well-led?

Good

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

The PPG said that they are actively promoting the formation of a virtual group to engage patients from across the population groups in the running of the practice. We saw this was included on the practice's website.

The PPG had supported the practice in improving access for patients with disabilities and they were in the process of organising a breast cancer day in conjunction with health professionals. Members of the group said that when they needed to attend the practice as a patient they would observe interactions between staff and patients and report back on what they had observed to the practice, both negative and positive observations. A suggestions box was available for patients in the waiting area and staff were able to complete a 'raising concern form' anonymously if needed.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at 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 training where guest speakers and trainers attended. The practice manager had commenced a fast track management course, which was being funded by the practice.

The practice was a GP training practice and mentored third year medical students from Southampton University, along with doctors training to be GPs. The practice had two GPs who were responsible for training doctors to be GPs.