Bridgemary Medical Centre

Quality Report

2 Gregson Avenue
Bridgemary
Gosport
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Date of inspection visit: 9 December 2014
Date of publication: 19/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Bridgemary Medical Centre, 2 Gregson, Avenue, Gosport, Hampshire, PO13 0HR on 9 December 2014. Overall the practice is rated as good.

We found that Bridgemary Medical Centre is a good practice overall with a strategy and track record of continuous improvement for the care and responding to the needs of patients living in the area.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the population groups we looked at.

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.

• Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.

• Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.

• Information about services and how to complain was available and easy to understand.

• Patients said they were satisfied with the appointments systems and that there was continuity of care, with urgent appointments available the same day.

• The practice had good facilities and was well equipped to treat patients and meet their needs.

• There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

The practice was a training practice and the practice leaflet explained that medical students spent part of their training from Southampton.

Summary of findings

Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice nurse.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Staff followed suitable infection control practices and the equipment and the environment were maintained appropriately.

Vaccines, medicines and prescriptions kept on the premises were stored suitably and securely. There were systems for the receipt, storage, record and administration of vaccines.

The practice had suitable arrangements in place for dealing with emergency situations and we saw policies which related to any interruption to the service provided.

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 National Institute for Health and Care Excellence (NICE) and used it routinely. Patient's 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 to provide effective care.

Are services caring?

Good

The practice is rated as good for caring.

Patients said that they were well informed about their care and treatment. We observed people being treated with dignity and respect. Staff provided privacy during all consultations and reception staff maintained patient privacy, dignity and confidentiality when registering or booking in patients.

The patients we spoke with, and the comments we received were complimentary of the care and service that staff provided.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for responsive.

The practice obtained and acted on patient's feedback. The practice learned from patient experiences, concerns and complaints to improve the quality of care.

The practice understood the needs of their patient population and this was reflected in the setup of the practice environment and systems used to meet some of the needs of their patients.

Patients told us they could always get an emergency appointment and waiting time for routine appointments was satisfactory.

Are services well-led?

Good

The practice is rated as good for well-led.

There was a clear leadership structure and staff felt supported by management and a culture of openness and honesty was encouraged.

The staff worked as a team and ensured that patients received a high standard of care. Staff had received inductions, regular performance reviews and attended staff meetings.

Risks to the safe and effective delivery of services were assessed and addressed in a timely manner. A suitable business continuity plan was in place. The practice had a number of policies and procedures to govern activity and regular governance meeting had taken place.

The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group.

Summary of findings

The six population groups and what we found

We always inspect the quality of care for these six population groups.

Older people

Good

The practice is rated as good for the care of older people.

Nationally reported data showed the practice had good outcomes for conditions commonly found amongst 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. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for people with long-term conditions.

Patients in this population group received safe, effective care which was based on national guidance. Care was tailored to patient needs, there was a multi-disciplinary input and was reviewed regularly.

The practice provided regular clinics for patients with diabetes, respiratory and cardiac conditions. The practice had two nurses who had received training and provided diabetic care and chronic obstructive pulmonary disease care in their own clinics.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people.

The practice followed national protocols and staff were aware of their responsibilities and the various legal requirements in the delivery of care to people in this population group. They worked with other health and social care providers to provide safe care.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us, and we saw evidence, that children and young people were treated in an age appropriate way and recognised as individuals. We were provided with good examples of joint working with midwives and health visitors.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working age people (including those recently retired and students).

Summary of findings

There was an appropriate system of receiving and responding to concerns and feedback from patients in this group who had found difficulty in getting appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group whose circumstances may make them vulnerable.

There was evidence of good multidisciplinary working with involvement of other health and social care workers. Staff were trained on safeguarding vulnerable adults and child protection.

The practice worked with local charities to see patients who found it difficult to attend the practice and provided care for patients who were vulnerable to abuse.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including patients with dementia).

The practice ensured that good quality care was provided for patients with experiencing poor mental health. The practice offered proactive, personalised care that met the needs of the older people in its population and had a range of enhanced services, for example in dementia.

Summary of findings

What people who use the service say

During our visit we spoke with 21 patients, including one member of the patient participation group (PPG) and reviewed 22 comments cards from patients who had visited the practice in the previous two weeks. All the feedback we received was positive. Patients were complimentary about the practice staff and the care and treatment they received. Patients told us that they were not rushed, that the appointments system was effective and staff explained their treatment options clearly. They said all the staff at the practice were helpful, caring and supportive.

Bridgemary Medical Centre

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 a specialist advisor practice manager and an expert by experience. Experts by Experience are members of the inspection team who have received care and experienced treatments from a similar service.

Background to Bridgemary Medical Centre

Bridgemary Medical Centre, 2 Gregson, Avenue, Gosport, Hampshire, PO13 0HR is a general practice (GP) surgery that provides NHS services. The practice was located close to the centre of Gosport.

The practice was well established and had been located at the medical centre for many years.

At the time of our visit the practice had five GPs, two female and three male. The practice had two practice nurses a practice manager and a full complement of administration and reception staff. All the consulting rooms and waiting areas afforded good disabled access. The practice had and about 8,500 patients on its list.

Out of Hours urgent medical care was provided when the practice was closed Monday to Friday and all day and night at the weekends and public holidays.

The CQC intelligent monitoring placed the practice in band three. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the practice to send us information about themselves, including their statement of purpose, how they dealt with and learnt from significant events and the roles of the staff. We carried out an announced visit on 9 December 2014.

During our visit we spoke with a range of staff including GPs, practice nurses, practice manager, administration staff

Detailed findings

and reception staff. We spoke with patients who used the service. We reviewed comment cards where patients and members of the public 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)

The practice profile data from Public Health England showed that there was above the average number of patients in the age groups 50 to 75 for females and 15 to 25 for males. The area was shown to be in the fifth less deprived decile. The average life expectancy indicator showed 77.7 years for males and 81.8 years for females. 79% of patients surveyed said that they were satisfied with the opening hours, 82.8% were satisfied with phone access.

Good

Are services safe?

Our findings

Safe Track Record

The practice GPs met on a regular basis to discuss safety of patients and safe care of patients. Any learning points were discussed openly and any actions were taken and system changes were made where appropriate. We looked at examples of audits with the full cycle of standard-setting, first cycle audit, a discussion with peers, agreeing changes, implementing them and then re-auditing to see whether it has made a difference or not. We saw evidence of reflection at the end of the full cycle, regardless of whether the desired change was achieved or not.

An example seen was an audit of patients coded for diabetes. The audit took place two times a year and a sample of patients were reviewed with regards to eight care processes completed including body mass index, blood pressure, smoking status, foot risk assessment. Actions were then agreed to reduce risks for patients on an individual basis.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. We saw some reports of those events and were able to discuss the process for recording incidents with the practice manager and the GPs. All serious events were discussed at GP partners meetings and practice meetings. This provided senior staff with the opportunity to discuss the incident and to record any learning points.

We saw an example where systems within the practice had been changed to minimise further risks. It was found that the patient's toilet showed signs that drugs misuse had taken place. This was reported quickly and advice was given for needle stick injuries. A risk assessment was made for cleaners and the toilet was locked with a notice to ask for key at reception. The toilet was kept under this regime for four weeks and monitored by staff for people coming into the practice just to use the toilet. The toilet was checked on a more regular basis for any unusual objects hidden and the cleaning company was asked to make sure policies were in place for their staff regarding health and safety.

Reliable safety systems and processes including safeguarding

Patients were protected from the risk of abuse, because the practice had taken reasonable steps to identify the possibility of abuse and prevent abuse from happening. Staff at the practice had taken part in training in safeguarding children and vulnerable adults at an appropriate level for their role. One of the GP partners who took the lead in safeguarding had taken part in higher level three training in the subject. Staff we spoke with were clear about their responsibilities to report any concerns they may have. Staff were able to tell us what actions they would take if they had any concerns. Child safeguarding conferences were attended by a GP when able or a full report was submitted. The GPs discussed safeguarding notifications and the practice sent the information to the specific GP handling the case or the lead GP.

Staff were also aware of the practice "whistleblowing" policy and understood it.

The practice offered patients the services of a chaperone during examinations if required. A chaperone is a person who serves as a witness for both a patient and a medical practitioner as a safeguard for both parties during a medical examination or procedure. We saw that details of this service were contained in the practice leaflet and how to ask for a chaperone if required. Staff said that this service was offered to patients.

Medicines Management

Arrangements were in place in relation to the management of medicines at the practice. These included safe storage, records and disposal.

The practice maintained a log of medicine refrigerator temperature checks. Staff were aware of protocols to follow if the refrigerator temperature was not within safe temperatures ranges. We saw that the medicines cupboard and the vaccines refrigerator in the nurse's treatment rooms were securely locked.

There was a GP lead for prescribing and regular audits and reviews of the prescriptions of people with long term conditions was undertaken using the data collection tools on the practice computer systems. Yearly prescription reviews were undertaken to ensure that the treatment was still relevant and necessary. The practice worked closely with the Clinical Commissioning Group pharmacy advisor

Good

Are services safe?

to oversee prescribing and medicines management. The practice was aware that they had areas of relatively high prescribing in certain antibiotics and were addressing this on a case by case nature.

Prescription pads were securely kept in a locked cupboard within a designated area of the practice and there a system for monitoring and recording use.

We checked the emergency medicines kit and found that all the medicines were in date. There was a log maintained with the expiry dates of all the medicines available in the kit. The vaccinations were stored in suitable refrigerators at the practice. All the medicines and vaccines that we checked were within their expiry date.

Cleanliness & Infection Control

A lead nurse was responsible for infection control procedures at the practice. There were appropriate policies and procedures in place to reduce the risk and spread of infection.

Hand washing guides were available above all sinks in clinical and patient areas. There were bacterial soap pump dispensers and hand towels in all areas. Personal protective equipment (PPE) such as gloves and aprons were available for staff and they were aware of when PPE should be used. There was good segregation of waste. Clinical waste was disposed of appropriately and after being removed from the practice was kept in locked waste bins to await collection.

Patients we spoke with commented positively on the standard of cleanliness at the practice. The nurses' treatment room appeared very clean and well maintained. Work surfaces were easily cleanable and were clutter free. The room was well organised with well displayed information and clean privacy curtains, sharps box and pedal operated waste bins.

During our visit we saw that staff cleaned the toys in the waiting area with wipes after they were played with by children.

Equipment

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. These were checked regularly by the practice nurses to ensure the equipment was working and the medicines were in date so that they would be safe to use should an emergency arise. The practice had an Automated External Defibrillator (AED) (an AED is used in the emergency treatment of a person having a cardiac arrest).

Staff had taken part in emergency life support training and were able to describe their training and felt confident that they could respond appropriately to an emergency in the practice.

Regular checks were undertaken on the equipment used in the practice. Examples of recent calibration checks of equipment by a contactor were seen. Continual risk assessing took place in the different areas of the practice and we saw evidence of the assessments in the health and safety file.

Staffing & Recruitment

The practice manager and GPs we spoke with told us that they felt the stable and experienced work force provided a safe environment for their patients. Staff at this practice worked as a team to cover the practice opening hours and would adjust their hours to cover any sickness or annual leave.

The provider had a suitable process for the recruitment of all clinical and non-clinical staff. The practice carried out pre-employment checks which included evidence of satisfactory conduct in previous employment, and where required criminal record checks, using the Disclosure and Barring Service. Newly appointed staff received an induction which included explanation of their roles and responsibilities and access to relevant information about the practice including relevant policies and procedures.

Monitoring Safety & Responding to Risk

Risk assessments were carried out for safety in the practice and emergency procedures were carried out such as fire alarm testing and evacuation procedures. Changes to risk were monitored and responded to as and when required.

The practice conduct regular fire drills to ensure fire safety was high . Continual risk assessing areas of the surgery and evidence of the assessments was found in the Health and Safety file.

Fire risk and Legionella policy documents were found. Equipment testing and fire extinguisher testing were up to

Good

Are services safe?

date. An up to date and resolved accident book was available behind reception. Equipment was checked regularly and when sourcing new equipment, required standards were checked.

Arrangements to deal with emergencies and major incidents

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. We saw that the practice had a business continuity plan. This is a plan that records what the service will do in an emergency to ensure that their patients are still able to receive a service. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice took into account national guidelines such as those issued by the National Institute for Health and Care Excellence (NICE). The practice had regular meetings where clinical and business issues relevant to patient care, and significant events and complaints were discussed. There were periodic multi-disciplinary meetings attended by GPs and nursing staff to discuss the care of people.

We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them.

The meetings covered various clinical issues, an example seen related to individualising new patient care; all new patients were offered new patient checks. Chronic disease management appointments were offered as appropriate, as well as GP appointments when required. We saw evidence that the practice worked closely with the community diabetic team to assess diabetic patients and the team did not have any concerns about the diabetic care being offered at the practice.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audit cycles. The practice had systems and processes in place to ensure that standards of care were effectively monitored and maintained. The practice carried out regular clinical audits to ensure the treatment they offered patients was in line with relevant guidance. There was evidence of learning from the audit process. Examples seen were diabetic and Chronic Obstructive Pulmonary Disease (COPD) audits. The practice worked with the community diabetic team and held meetings where patients were invited to discuss their long term care. Patients were happy with the outcomes of the meetings and the treatment changes recommended.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for areas such as the management of respiratory (breathing) disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice managed patients with long-term conditions and staff were aware of procedures to follow to ensure that patients on the Quality and Outcomes Framework (QOF) disease registers were contacted and recalled at suitable intervals. The practice used QOF to improve care for example, by exploring clinical changes for conditions such as diabetes. The practice used the QOF to evidence that they had a register of patients aged 18 and over with learning disabilities, had a complete register available of all patients in need of palliative care or support irrespective of age and that the practice had regular (at least three monthly) multidisciplinary case review meetings where all patients on the palliative care register were discussed. The Quality and Outcomes Framework (QOF) is a system for the performance management and payment of general practitioners (GPs) in the National Health Service (NHS) in England, Wales, Scotland and Northern Ireland. It was introduced as part of the new general medical services (GMS) contract in April 2004, replacing various other fee arrangements.

Effective staffing

Staff we spoke with all told us that they felt well supported by their colleagues and the practice manager. They said they had been supported to attend training courses to help them in their professional development and that there was a culture of openness and communication at the practice and they felt comfortable to raise concerns or discuss ideas.

Staff received appropriate support and professional development. The provider had identified training modules to be completed by staff which included amongst others safeguarding of children and vulnerable adults. Staff were aware of and had received information about safeguarding and training in infection control and basic life support skills. Staff received supervision and an annual appraisal of their performance.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines.

Good

Are services effective?

(for example, treatment is effective)

Those with extended roles seeing patients with long-term conditions such as COPD and diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The provider worked in co-operation with other services and there was evidence of good multi-disciplinary team working. An example seen was working with the Clinical Commissioning Group medicines management team.

Staff told us they felt they worked well as a multidisciplinary team and that there was good involvement of other social and healthcare professionals especially in the care of older patients. The practice had monthly meetings with the palliative care team and district nurse to improve the quality of life for patients and their families.

The practice had regular meetings with the health visitor team and discussed the needs of children under five years old and all children at risk.

Information Sharing

Where required information was shared in a responsible and comprehensive way. An example seen was that care plans for vulnerable were shared and uploaded to ambulance and Out of Hours computer systems.

The practice lead on information governance explained that staff were given training and discussed confidentiality. Staff we spoke with were able to explain the training they had received about information sharing. An example given was that when insurance companies requested details of patient notes no information was released without first obtaining full consent from the patient and checking with the clinical staff.

Another example was there were notes alerts for vulnerable patients. There were also warnings in the notes about patients who were particularly vulnerable and how the practice was active to protect their safety.

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 in their practice. We spoke with nurses who demonstrated a good understanding of their responsibilities for obtaining valid consent from patients, and patients said that they understood about giving consent and did not feel pressured into agreeing to treatment. This highlighted how patients should be supported to make their own decisions. When the GP or the nurses deemed the patient did not have capacity to consent then they discussed the matter with the next of kin, carer as well as fellow professionals.

The practice had challenges associated with teenage pregnancy rates and had taken part in a contraception initiative aimed at their teenager patients which encompassed the Gillick principles of consent. This test was used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions.

Health Promotion & Prevention

The practice ensured that where applicable people received appropriate support and advice for health promotion. Information available to patients was effective; there was an extensive pin-board on the wall in the waiting room which was tidy, up to date, and contained notices relevant to the demographics of the patients.

A Health Matters board with several information leaflet racks was located in the waiting area and held a good variety of information. There was a television in the waiting area which had a rolling programme of health promotion and prevention information including smoking cessation, flu jabs and shingles vaccination. Patients who required support for drug addiction were directed to a local drugs addiction team.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

Information was available in easy to read formats and the practice had systems available on their web site for patients whose first language was not English.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the CCG, and again there was a clear policy for following up non-attenders by the practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

Staff told us how they respected patients' confidentiality and privacy. The receptionists we observed were calm, efficient, kind and discreet, and multitasked effectively. There were no queues at the desk, and patients were directed swiftly to where they needed to be. The reception was accessible to patients with disabilities with lower desk height for wheelchair users. There were signs that asked for patients to respect the privacy of other patients. The practice had an area set aside for patients to use if they required further privacy to discuss any matter.

The practice ensured that the Out of Hours service was aware of any information regarding their patients' end of life needs. This meant that patients at all stages of their health care were treated with dignity, privacy and compassion.

Care planning and involvement in decisions about care and treatment

All the patients we spoke with and the comment cards completed were complimentary of the staff at the practice and the service received.

Patients told us that they felt listened to and involved in the decisions about the care and treatment. They expressed the view that they were given appropriate information and GPs took time to support and explain their care or treatment.

We saw that patients with long-term conditions were involved in their treatment and care plans and in agreeing with them.

Patient/carer support to cope emotionally with care and treatment

The practice supported patients following discharge from hospital. Discharge letters were monitored and patients were supported on returning home. Patients had been contacted by the practice and care and treatment needs were followed up.

Notices in the patient waiting room, on the TV screen and patient website also told people how to access a number of support groups and organisations. An example seen was the Gosport Voluntary Action, befriending service which seeks to support people to continue to be part of their community.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had worked with a patient participation group to produce a practice survey for the wider practice population. The patient survey undertaken in 2014 showed that patients were happy with the service and that it met their needs. We also found this to be the case in our discussion with patients and from the comment cards submitted by patients attending the practice on the day of our visit.

Child immunisations were called regularly and non-attenders are notified to the health visiting service. The Practice had achieved over 90% of its immunisation cohort of children.

We found the practice was responsive to people's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. An example seen was an action plan being discussed with the medicines management team to implement service improvements in such things as nutrition. This involved a review of prescribing of oral supplements to ensure appropriate initiation, monitoring and duration of treatment.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). An example seen was the reorganisation of the reception so that patients found it easier to approach and use the reception desk and have more privacy when talking to the receptionist. The reception staff found that the queues for the reception had decreased. The reception also had a lower desk area installed for patients who were wheelchair users.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services.

The practice had access to online and telephone translation services for patients whose first language was not English.

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.

The premises and services had been adapted to meet the needs of people with disabilities. The practice had accessible toilet facilities in the waiting room and had adapted to reception area to suit the needs of patients with disabilities.

Access to the service

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

Appointments were available from 08.30 am (the practice and telephone lines opened at 08.00am but appointments started at 08.30am) to 6.30 pm on weekdays. The practice offered appointments up to four weeks in advance.

The practice did not employ locum GPs and each GP covered annual leave and sickness. The practice felt that this provided a continuity of care for the patients.

Each day one of the GPs was duty GP and dealt with urgent appointments. The duty GP was either be able to give telephone advice or offer five minute appointment slots for urgent issues. The GPs met every day after morning surgery to discuss patients and provide advice on care and treatment to each other. The GPs supported the duty GP with seeing urgent patients after they had completed their own appointments.

As a result of patient feedback the practice introduced extended surgeries for patients who found it difficult to

Good

Are services responsive to people's needs?

(for example, to feedback?)

attend during normal business hours. This was on a four week rota, week one there were extended hours from 6.30pm to 7.30pm on a Tuesday with either two or GPs available. Week two, appointments were available 6.30pm to 7.30pm on a Thursday with two GPs available. Week three, appointments were available Saturday mornings 8.00am to 11.30 am with three GPs available and week four had extended hours Monday 6.30pm to 7.30 pm with three GPs available.

The practice nurses saw people by appointment for nursing matters such as vaccinations, cervical smears, suture removal, ear syringing and dressings.

Both GPs and nurses ran clinics for chronic diseases. Patients were called back annually for a chronic disease check-up and the practice stressed to patients that it was important to make and keep these appointments.

The practice provided home visits, but asked that they only be requested for patients who were unable to attend the practice because of serious illness or infirmity, for example, for older patients and long term conditions. Requests for home visits after 11.30am were dealt with by the duty GP.

The practice was closed from 12.30 to 1.30pm on the second Wednesday of each month for staff training and meetings. If patients required urgent medical attention during that time they were asked to phone the practice for advice.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, a patient said that they had called in that morning for an emergency appointment and were seeing a GP within three hours.

For older people and people with long-term conditions longer appointments were made available when needed. Appointments were available outside of school hours for children and young people.

People whose circumstances made them vulnerable were supported to attend the practice and the practice was working to understand the needs of the most vulnerable in the practice population. Patients experiencing poor mental health within the practice population including hard to reach groups were offered longer appointments for those that needed them.

Listening and learning from concerns & 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 there was a designated responsible person who handles all complaints in the practice.

Complaints were responded in a timely manner and audits were undertaken regularly to review the working procedures and practices which were amended where applicable. The complaints had been analysed to try and ensure that there were no repeats. The practice manager used the information to create learning points where required and these were fed back to staff for information. Also to support them where processes were correct and followed and any complaint was unfounded.

The practice had a culture of openness and learning. Staff told us that they felt confident in raising issues and concerns. We saw that incidents were reported promptly and analysed. All complaints were discussed meetings with the clinical staff; evidence of this was seen in the minutes from the meetings.

We looked at seven complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and there was openness and transparency in dealing with the compliant.

A complaints leaflet was available on the reception desk and contained information on referring the complaint to the Parliamentary Ombudsman.

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 and strategy that placed the quality of patient care as their priority. The practice values and aims were described as being patient centred and providing a caring service to our patients. These were communicated to patients in the waiting area and on the practice website. Staff were committed to the practice aims and described the ethos of the practice as being focused on high quality patient care.

There was a caring ethos of putting patients first that resulted from the GP leadership. Staff told us the practice had an open and democratic way of working to ensure that everybody felt part of the team.

The practice vision and values were included in the practice mission statement which gave the aims as providing effective, caring patient services to all registered patients while maintaining the work-life balance of GPs and staff. The main aims were to provide a high standard of primary medical care to all patients and respond efficiently and effectively to changing health care demands.

Governance Arrangements

We saw good working relationships amongst staff and an ethos of team working. Partner GPs and the practice nurses had areas of responsibility, such as, prescribing or safeguarding it was therefore clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice.

The practice used the Quality and Outcomes Framework (QOF) to measure their 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 governance meetings and action plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

We were shown a clear leadership structure which had members of staff in lead roles. For example, a GP partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

The practice sought and acted on feedback from users, public and staff.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We reviewed a number of policies, for example, the equality and diversity policy, complaints handling protocol and recruitment policy in place to support staff. Staff we spoke with knew where to find these policies if required.

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received.

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

The practice had an active patient participation group and the practice worked with them to help improve the care services. All the patients we spoke with and the comment cards patients had completed were complimentary about the staff at the practice and the service that patients had received. Patients told us that they felt listened to and involved in the decisions about their care and treatment.

Management lead through learning & improvement

The practice undertook and participated in a number of regular audits. We saw that incidents were reported promptly and analysed. We noted examples of learning from incidents and audits, and noted that where applicable practices and protocols had been amended accordingly.

The practice was a training practice and the practice leaflet explained that medical students spent part of their training from Southampton.