Dr O'Donovan and Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Dr O'Donovan and Partners on 7 January 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, well-led, caring and responsive services. It was also good for providing services for older people, people experiencing poor mental health (including people with dementia), people whose circumstances may make them vulnerable, people with long term conditions. families, children and young people and working age people (including those recently retired and students).

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.
- 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. Results from the GP survey to March 2014 showed that 89.5% of those patients surveyed felt that their overall experience of the practice was either good or very good
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice sought feedback from patients, which it acted on.

Summary of findings

Importantly the provider should:

- Ensure registered patients with a learning disability have access to medical reviews where this is not provided by the practice.
- Ensure any member of staff acting as a chaperone is trained for the role
- Provide guidance for staff in regard to the actions to take if the temperature of a medicines fridge is outside the recommended safe range.
- Review the information provided for patients in the practice leaflet and on the practice website to ensure it is accurate and consistent.
- Take action to address the difficulties experienced by patients who attempted to contact the practice by telephone.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from 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. However this did not apply to staff who provided chaperone duties these people had not received appropriate training for the role. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

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

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. We noted learning from complaints was discussed and shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active. Staff had received inductions and annual appraisals there were regular staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. Regular meetings were held with integrated care and multi-disciplinary care teams. Patients receiving end of life care and support also had care plans which were shared using the special notes system with out of hours providers. Flu vaccinations for over 65 years were higher than the national average. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. Those patients aged over 75 who had not been seen in the practice in the previous 12 months could request a consultation and were assigned a named GP.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. The practice was aware of those patients with long term conditions and had processes in place to make urgent referrals to secondary care should it be necessary or when longer appointments or home visits were needed. All these patients were offered structured annual reviews to check their health and medication needs were being met. Patients were involved in developing their care plan. Flu vaccinations for patients within the at-risk groups were higher than the national average. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. The practice held weekly antenatal clinics and baby clinics. All the GPs provided antenatal care and family planning services. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

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 and flexible. The practice offered online services which enabled patients to book appointments or request prescriptions. There was a full range of health promotion information and screening offered that reflected the needs for this age group. NHS health checks were offered to all patients under the public health scheme and those patients between the ages of 16 and 75 who had not been seen at the practice for more than three years could request a health check. Pre bookable appointments were available until 8 pm two evenings each week for patients who could not attend during normal working hours.

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 was aware of those patients living in vulnerable circumstances and those with a learning disability. They were aware of the needs of this group of patients and ensured they had access to appointments at times which suited them. GPs and staff were aware of the added needs of their patients with a learning disability and the support these patients required to access GP appointments. Some of these patients were on the practice's admission avoidance scheme. However registered patients with a learning disability who do not have an annual health assessment by the practice should be supported to have access to medical reviews.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Vulnerable patients were advised of 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 and documentation of safeguarding concerns. Staff had received training in safeguarding at a level appropriate to their role.

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 people with dementia).

Summary of findings

The practice population included a number of military veterans (ex-service personnel) who may be at additional risk. The electronic system highlighted to staff and GPs those patients who were veterans.

When appropriate patients experiencing poor mental health were signposted to other support organisations. Patients were referred by their GP to a local counselling service and staff were also trained to direct patients to the service directly if necessary, or advise patients how to make a self-referral to this service.

The dementia diagnosis rate for this practice was higher than the national average.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection. We reviewed 42 comment cards which had been completed by patients in the two weeks leading up to our inspection and spoke to representatives of the Patient Participation Group.

Generally patients were very complimentary about the practice staff who they said were caring, friendly, understanding and patient. We received conflicting information from patients about their experiences when making appointments. The majority had been able to make appointments at a time to suit them or had been seen the same day when medically necessary. However a number commented on the difficulty arranging appointments and the length of time they had to wait before going in to see the GP. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis or medicines in a way they could understand.

The last patient survey was conducted by the practice in September 2013 the results from this survey showed that 83% of those that responded said it was either fairly easy or very easy to get an appointment at a time they wanted with 74% of those indicating the appointment was with the GP of their choice. The survey showed that 96% were very satisfied or fairly satisfied with the care they received from the practice and 93% would be happy to recommend the practice to family and friends. Results from the GP survey to March 2014 showed that 89.5% of those patients surveyed felt that their overall experience of the practice was either good or very good.

Areas for improvement

Action the service SHOULD take to improve

- Ensure registered patients with a learning disability have access to medical reviews where this is not provided by the practice.
- Ensure any member of staff acting as a chaperone is trained for the role
- Provide guidance for staff in regard to the actions to take if the temperature of a medicines fridge is outside the recommended safe range.
- Review the information provided for patients in the practice leaflet and on the practice website to ensure it is accurate and consistent.
- Take action to address the difficulties experienced by patients who attempted to contact the practice by telephone.

Dr O'Donovan and Partners

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 Dr O'Donovan and Partners

Dr O'Donovan and partners is located at 262 Devonshire Avenue, Southsea, Hampshire PO4 9EH. The practice, also known as The Devonshire Practice, is part of the Portsmouth Clinical Commissioning Group.

Approximately 5,658 patients are registered with the practice. A range of services including management of long term conditions, childhood immunisations and health screening programmes are offered. The practice is located in a part of Hampshire where deprivation levels are slightly higher than the England average. The practice population in respect of age reflects the Clinical Commissioning Group and National averages.

The practice has one male and three female GP partners. The GPs in total provide the equivalent of three full time GPs. The GPs are supported by two practice nurses, a practice manager, a reception manager and administrative and reception staff.

The practice provides services under a personal medical services (PMS) contract.

This was a planned comprehensive inspection and the practice had not been inspected previously.

The practice has opted out of providing out of hours services to their patients. There are arrangements in place for out of hours services to be provided by an alternative provider when the practice is closed. Patients can access these services through the NHS 111telephone number. Details of the out of hours service are displayed at the practice, in the practice information leaflet and on their website.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health

and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting Dr O'Donovan and Partners we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Portsmouth Clinical Commissioning Group. We carried out an announced inspection visit on

Detailed findings

7January 2015. During our inspection we spoke with patients and a range of staff, including GPs, the practice nurses, the practice manager and reception and administration staff.

We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation including relevant monitoring tools for training, recruitment, maintenance and cleaning of the premises.

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 patient's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of patients 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 used range of information to identify risks and improve patient safety. Significant events, incidents and national patient safety alerts were recorded, shared and learned from. Comments and complaints received from patients were reviewed and learned from. The staff we spoke with were aware of their responsibilities to raise and report concerns.

We reviewed safety records, incident reports and minutes of meetings for the last 12 months where these had been discussed. This showed the practice had managed these consistently over time and learning was identified and action taken. For example staff discussed how to improve the safety of prescription requests following a near miss. This occurred when prescription requests for two patients had been stapled together by a community pharmacist. A number of changes and checks had been developed to ensure it was clear which patient each prescription was for; this had been shared with the pharmacy and the Portsmouth Clinical Commissioning Group.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of eight significant events that had occurred during the last 12 months and we were able to review these. The records demonstrated what happened, the actions taken at the time, the result of the investigation, conclusions and learning from the event and actions to take. The GPs told us that significant events were discussed at weekly partners' meetings and shared with relevant staff.

Staff recorded incidents and were able to describe situations that would constitute a significant event and knew to report this to the practice manager. We tracked incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example the system for dealing with faxed information from the out of hours service had been emphasised with staff. This followed the receipt of a fax for a patient who needed a follow up appointment that was not handed directly to the duty GP. Where patients had been affected by something that had gone wrong, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated electronically to GPs and nurses. These were recorded and signed for by each person, they were also discussed and actions taken recorded at partners' meetings.

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. The GPs confirmed they had undertaken safeguarding level three in child protection. Staff had also received safeguarding adults training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in a safeguarding file which contained guidance and relevant contact details. Safeguarding concerns were also discussed at GP partner meetings.

The practice had a dedicated GP as lead in safeguarding vulnerable adults and children. They could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients and their families 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 or on an at risk register.

There was a chaperone policy, which was visible on the waiting room noticeboard. (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). The practice chaperone policy was that only nurses or GPs would act as a chaperone and that training would be provided. We were unable to confirm, from the training records we received from the practice, whether all nursing staff had been chaperone trained. The policy also stated that patient treatment records should document the name of any chaperone.

Good

Are services safe?

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear process for checking and recording that medicines were kept at the required temperature and the medicines fridges were alarmed to alert staff of any variance from safe storage temperatures. We noted that there was an occasion when the temperature recorded was 9 degrees Celsius when the optimum range is between two degrees and eight degrees. There was no explanation for these rises in temperature or the action taken. There was guidance available for staff on the storage and management of non-controlled drugs and vaccines. This document guided staff to report any problems to the nurses or practice manager. Staff told us they would always alert the duty doctor to any queries relating to the storage of vaccines.

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 saw evidence of an appropriate waste collection contract.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data and audits carried out by the practice GPs. For example, the safe use of medicines for osteoporosis and improving the continued monitoring of those patients at risk.

One of the GPs was the prescribing lead who regularly liaised with the prescribing pharmacist from the CCG. They attended external CCG meetings and shared information and new guidance with the other GPs at the practice meetings.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

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

Cleanliness and infection control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice nurses had undertaken training in infection control to enable them to provide advice to the practice on the subject. We looked at training records which showed that not all staff had received training in infection control and for some staff their training had taken place a number of years ago. We were told that infection control formed part of annual training but this was not recorded in the practice training records for individual staff members.

The practice had an infection control audit carried out by a third party every 12 months. The last audit had taken place in April 2014 and the actions identified were completed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a system for the management of risks posed by legionella (a term for particular bacteria which can contaminate water systems in buildings). The practice had carried out an assessment of the building in relation to Legionella, a number of years ago. We did not see a copy of this survey. The practice carried out regular procedures to minimise any risks such as running taps and maintaining water temperature however these procedures were not recorded.

Equipment

Staff we spoke with did not raise any concerns about the safety, suitability or availability of equipment. They told us that all equipment was tested and maintained regularly. We saw that medical equipment had been calibrated and

was functioning correctly and accurately. (Calibration is a means of testing that measuring equipment is accurate). Electrical items had been portable appliance tested (PAT tested) and were deemed safe to use.

Staffing and recruitment

The practice had a recruitment and training policy that set out the standards it followed when recruiting clinical and non-clinical staff. The practice also had a document detailing the employment checks that were required for NHS employees. This included a risk assessment in relation to the level of checks required for various roles. These checks included those undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave or other absences.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The GPs told us of the regular review of available appointments and ensured that GP leave was planned and covered by locum GPs to ensure the needs of patients were met.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included checks of the building, the environment and emergency alarms. Fire extinguishers were checked annually and staff underwent annual training in fire safety.

The practice had a health and safety policy. There were Control of Substances Hazardous to Health data sheets available for staff and the contracted cleaners

The practice ensured that appropriate risk assessments were carried out in relation to both patients and staff. For example a work station risk assessment had been started for all staff to assess the risks relating to posture and computer use.

There were emergency processes in place for patients with long-term conditions. Patients with long term conditions were offered same day appointments and longer appointments for certain medical conditions.

The practice responded to seasonal changes in risk. For example, there was a significant increase in the number of GP consultations requested before and after bank holidays. Practice staff described the systems they implemented to cope with the extra demand during this time.

There were processes in place to identify those patients at high risk of hospital admission with an alert attached to their electronic patient record.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records to show that all staff had received training in resuscitation in line with recent requirements. All staff asked, knew the location of the automatic external defibrillator (a machine which is used in the emergency treatment of a patient suffering a cardiac arrest), oxygen, and emergency medicines.

The practice had appropriate equipment, emergency medicines and oxygen to enable them to respond to an emergency should it arise. Processes were in place to check emergency medicines were within their expiry date and suitable for use. Staff checked the emergency medicines to ensure they would be safe to use should an emergency arise.

The practice had a business continuity plan which included what the practice would do in an emergency which caused a disruption to the service, such as a loss of computer systems, power or telephones. The plan had been tested when the practice and surrounding area suffered a power failure. As part of the business continuity plan appointment templates are printed off each night so staff were aware of the patients that were due to attend. The business continuity plan was further updated through the lessons learned from that event. The practice had arrangements in place to use other facilities which would allow them to continue to provide patient care should they not be able to operate from their current premises.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where best practice guidelines were discussed and the implications for the practice's performance and patients. 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. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they led in specialist clinical areas and the practice nurses supported this work, in areas such as diabetes and other long term conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of patients' conditions. For example we saw that one of the GP partners had reported on the need for antibiotic prescribing for a patient following surgery. The conclusions had been shared with the other GPs.

The GPs were aware of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with chronic obstructive pulmonary disease which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected cancer. We saw records which indicated that reviews of fast track and acute referrals were made, and that improvements to practice were shared with all clinical staff. The practice had identified that for 2013/2014 the diagnosis rates from their urology two week wait referrals was approximately 9.3% which was in line with the national average.

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

Management, monitoring and improving outcomes for people

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

The practice collected information about patients' care and the effectiveness of treatments. They used QOF to assess performance and completed the clinical audits that were required to fulfil the requirements of QOF. We saw evidence of complete clinical audit cycles one of which, an after death audit, showed the practice had identified actions they could take to improve end of life care for their patients. For example an effective system was put in place to make sure staff updated records accordingly and kept records such as the coordinating future care register updated. There was also evidence that as part of the practice's quality improvement programme they had worked with the clinical commissioning medicines management team to audit prescribing for patients with a variety of conditions to ensure it followed current best practice guidelines.

The practice 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 lung disease. Although the practice kept a register of their patients with a learning disability the practice had not signed up to offering an annual health check programme.

The IT system flagged up relevant medicines alerts when the GP prescribed medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

Good

Are services effective?

(for example, treatment is effective)

We noted that the most recent overall QOF (2013/2014) score for the practice was 99.2%, which was higher than the national average. Other areas where performance was higher than the national average included the uptake of vaccination for flu.

The practice held palliative care registers and met with the primary health care team weekly to discuss patient care.

QOF data available up to March 2014 showed that the practice had carried out 81% of the cytology screening for their target group.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff told us that they took part in training organised by the practice. For example GPs attended events organised by the clinical commissioning group and the practice organised specific in house training for the other staff. Training was also arranged in conjunction with neighbouring practices to share resources and costs. The practice nurses had attended training or gained further qualifications in subjects such as, tissue viability, diabetes, immunisations and end of life care.

GPs took part in a peer review appraisal; these appraisals would form part of their future revalidation with the General Medical Committee (GMC). All GPs were aware of their appraisal schedule and revalidation dates. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All the staff we spoke with in both nursing and administrative roles told us they were well supported by the GPs and the practice manager. There was an annual appraisal system in place for staff, these were carried out by the practice managers for administrative and reception staff and by a GP for the nurses. Staff had taken part in an annual appraisal and had been able to use the protected time to discuss any concerns they had around patient care and their own personal development.

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. Staff were clear about their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The duty doctor was responsible for checking any information from the out of hours service and was responsible for the action required. There were systems in place for GPs to cover for each other at times of holiday or non-working days. There was one instance identified within the last year when information from the out of hours service was not followed up appropriately. This event had been identified as significant and the practice could show the actions taken as a result to mitigate any future risk.

The practice held weekly team meetings to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. Other health care professionals such as health visitors were invited to these meetings and attended when they were able. District nurses and palliative care nurses attended the meetings and the practice and district nurses had a system in place to share information, district nurses collected information directly from the practice. The practice worked closely with MacMillan nurses and the local hospice to support patients at end of life. The practice had links with the talking therapy service and supported patients to self-refer for counselling.

Information sharing

Patient information was stored securely on the practice's electronic record system. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. The software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Patient records could be accessed by appropriate staff in order to plan and deliver patient care. We saw that information was transferred to patient records promptly following out of hours or hospital care. The practice retained historic paper patient records which were stored securely and used if necessary to review medical histories.

The practice ensured that the out of hours and ambulance service were aware of any relevant information relating to their patients. For example care plans that were in place for patients with complex medical needs were shared with the out of hours and ambulance services. These services were also made aware of any patient whose end of life care was being managed in their home. Letters and other

Good

Are services effective?

(for example, treatment is effective)

documents including discharge summaries, out-patient recommendations and shared care agreements about medicines from local hospitals, out of hour's providers and the ambulance service were received both electronically and by post.

Consent to care and treatment

Patients with a learning disability and those with dementia were supported to make decisions, which they were involved in agreeing.

GPs were all familiar with the Mental Capacity Act 2005. They explained they would involve the patient in the treatment or care choice and ask the relatives for support. They knew how to make a full assessment of a patient's capacity to make a decision.

GPs we spoke with demonstrated a clear understanding of Gillick competencies, to identify children aged less than 16 years of age who have the capacity to consent to medical examination and treatment and were familiar with using the assessment. (The Gillick competency test is used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.)

Reception staff were clear about their responsibilities in relation to information governance and the sharing of information. All patients who had given their consent to share information with a third party were clearly identified with a pop up alert on their electronic patient record.

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

Health promotion and prevention

New patients were able to have health checks when registering with the practice. Opportunistic screening and reviews were undertaken at GP appointments. Health promotion was also provided during the chronic disease recalls for patients with long term conditions.

The practice population reflected that of the average for England with a slightly lower percentage of teenagers. The prevalence of long term conditions among the practice population was slightly higher than the average nationally.

The practice had ways of identifying patients who needed additional support, and signposted patients to additional help.

The practice offered a full range of immunisations for children and flu vaccinations in line with current national guidance. The practice's performance on flu immunisation for 2013/2014 was 82.7% of the patients over the age of 65 years and 63.9% for pregnant women, both of these figures were above the national average. Data showed that the practice was performing well for meeting the health screening and health education needs of patients with diabetes. For example the percentage of patients with diabetes whose last measured total cholesterol (measured within the preceding 12 months) was 5 mmol/l or less was higher than the national and CCG average. The percentage of practice patients with diabetes was also higher than the average for England for having a record of a foot examination within the preceding 12 months.

The practice proactively followed up, by letter, those patients who failed to attend screening appointments, such as mammograms or bowel cancer screening.

There were no specific clinics for smoking cessation or diet advice. Staff offered support opportunistically or were able to signpost patients to specialised services, such as a local pharmacy who provided smoking cessation. The practice referred patients to health trainers or to pulmonary rehabilitation if necessary.

Travel vaccines were offered at the practice. Patients were directed to complete a travel questionnaire online before attending for the nurse appointment this enabled the practice to offer appropriate advice about the type of vaccinations required. This meant that most patients only had to visit the practice once for the vaccines to be administered.

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 July 2013 to March 2014 and a survey of 75 patients undertaken by the practice's patient participation group between October 2013 and January 2014. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 89.5% of patients rated the overall experience of the practice as good or very good. The practice was average for its satisfaction scores on consultations with doctors and nurses with 85% of practice respondents saying the GP was good at listening to them and 83.99% saying the last time they saw or spoke to a nurse, the nurse good or very good at involving them in decisions about their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 42 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and that staff were good at listening, helpful and friendly. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. A radio was played in the waiting room this prevented patients overhearing potentially private conversations between patients and reception staff. We saw this in operation during our inspection and noted that it enabled confidentiality to be maintained.

We saw from training records that staff had taken part in information governance training. Those we asked were able to demonstrate how they ensured patients' privacy and confidentiality was maintained.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the NHS England GP patient survey and NHS Choices. The evidence from all these sources showed patients were very satisfied with how they were treated and described the staff as polite, courteous and helpful. The NHS England GP survey showed that 89.5% of those who responded rated their overall experience of the practice as either good or excellent, which was slightly higher than the national average. The majority of patients who completed our comment cards said the GP or nurse they saw listened to them and gave them enough time during their consultation, they did not feel rushed.

Care planning and involvement in decisions about care and treatment

Patients said they were given enough time to discuss their concerns and were given clear information about treatment options open to them. Patients told us that their GP explained their treatment and all commented that there was enough time to discuss their needs. They also told us they felt listened to and supported by staff. They understood what had been said in order to make an informed decision about the choice of treatment they wished to receive. The comment cards we received were also positive and praised the polite, understanding and professional staff. One patient commented on their positive experiences during their pregnancy where they were fully involved in their care plan and contact with the practice was good, with all questions answered or worries discussed.

The results of the NHS England GP patient survey showed that 78.75% of respondents felt that the last time they saw or spoke to a GP, the GP was good or very good at involving them in decisions about their care, this was marginally lower that the national average.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

The practice ensured that the out of hours service was aware of any information regarding patients' end of life needs and ensured they received specific patient notes. This included individualised information about patients' complex health, social care or end of life needs. The practice supported their patients with end of life care in their own home if it was the patient's wish to die at home rather than in hospital.

The patients we spoke with on the day of our inspection and the comment cards we received highlighted that staff responded compassionately when they needed help and provided support when required. For example one patient commented positively on the support they received after bereavement. The practice had a system in place to support the recently bereaved and worked collaboratively with district nurses to care for the bereaved families.

Indicators were on patients' records to show whether the patient had a carer or was cared for by another person. This system alerted GPs to provide information available for carers to ensure they understood the various avenues of support available to them. The practice website gave carers information about the support available to them and those they cared for.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Whenever possible patients were offered the GP of their choice. All patients over 75 had a named GP in line with current recommendations.

The practice was aware of the practice population in respect of age, culture, and number of patients with long term conditions. The practice had responded to the needs of the practice population. The practice had a number of patients of working age. Extended hours opening until 8.00 pm were available every Monday and Tuesday for patients who could not attend during normal working hours.

The practice worked collaboratively with Portsmouth Clinical Commissioning Group and other practices to discuss local needs and service improvements that needed to be prioritised. The practice was joining a federation with other Portsmouth city practices and had worked collaboratively with local GP practices. This included organising training workshops for staff to provide more effective care for their patients.

The practice had a patient participation group (PPG). The practice's patient feedback survey had been designed based on the priorities identified and agreed by the practice and the PPG. The PPG had been consulted about the questions for the annual patient survey carried out between October 2013 and January 2014. Following the survey the PPG and the practice had met to discuss the findings of the survey and suggested areas of change. We saw that actions had been recorded such as ways to decrease the number of missed appointments. We saw that some of the actions were complete, however there was no record of all actions being complete or whether the actions taken had reduced the number of missed appointments.

Two members of the PPG made themselves available to the inspection team and were keen to promote and compliment the responsiveness and friendliness of the practice. They explained how they worked with the practice for the benefit of patients. PPG meetings were attended by the practice manager.

Tackling inequity and promoting equality

The ground floor of the practice premises were accessible, via a ramp, to patients who were wheelchair users or required walking aids. There were arrangements in place for those patients with mobility issues to be seen in a consulting room on the ground floor.

Staff had access to a language line if needed for patients whose first language was not English and needed an interpreter.

Access to the service

The practice was open at 8.30am to 6.30pm every day. Routine appointments could be booked in person, by telephone or on line. The practice offered a combination of pre bookable and on the day GP appointments, with a variety of times offered, these consultations could be face to face or by telephone. There was information about appointments available in the practice leaflet and on the practice website, however the information was conflicting as the leaflet said appointments could be booked 14 days in advance whereas the web site said 28 days in advance. Both information sources stipulated that all appointments were 10 minutes long and that appointments were on a 'first come first served basis', however exceptions were made for serious and very urgent appointments.

Patients we spoke with and a number of those who completed our comment cards gave conflicting information on the availability of appointments. One patient commented that the easiest way to get a same day appointment was to visit the practice in person at 8.30am as it was difficult to get an appointment by telephoning. This was echoed by the NHS England GP survey which showed that 53.5% of respondents found it easy to get through to someone at the GP practice on the phone; this was in comparison to the national average of 75.4%. However some patients had not found any difficulty booking a GP consultation

Information on the practice website included how to arrange home visits and nurse appointments. The practice also directed patients to a local treatment centre and pharmacists for advice or treatment. 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.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Listening and learning from concerns and complaints

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

Information was provided to help patients understand the complaints system this was set out in the practice leaflet and displayed in the practice; however there was no information for patients on the practice website.

Evidence seen from reviewing a range of feedback about the service, including complaint information, showed that the practice responded quickly to issues raised. The record of complaints showed that all complaints had been responded to in a courteous manner by the practice manager. The practice analysed complaints to ensure that any themes or trends were identified and to improve the service patients received as a result of feedback. No trends or themes had been identified from the summary of complaints for the previous 12 months. There was evidence of shared learning from complaints with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver a caring service for their patients.

We spoke with four GPs, two practice nurses, the practice manager and reception and administration staff. They all knew and understood the practice values and knew what their responsibilities were in relation to these. All staff felt able to make suggestions to improve outcomes for patients.

The GP partners met weekly and invited other staff or healthcare professionals, if relevant to the agenda. These meetings were held to share and discuss information to improve effective patient care.

The practice worked with nearby practices to share resources and improve services for their patients.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. The practice held governance meetings; additionally significant events and complaints were regular agenda items for weekly partners' meetings. Partners' meetings were used to discuss performance, quality and risks.

The practice used the Quality and Outcomes Framework (QOF) to measure their performance and to monitor the effectiveness of some aspects of the practice. The QOF data for this practice showed it was a high performing practice within the Portsmouth Clinical Commissioning Group (CCG), they had achieved 99.2% of the available points. Staff and GPs told us they had regular discussions to ensure they were constantly aware of the practice performance.

The practice met with other practices from the Portsmouth regularly. The prescribing lead GP from the practice met with the prescribing pharmacist from the CCG. This gave the practice the opportunity to measure their service against others and work collaboratively to identify best practice.

Clinical audits were undertaken by the practice GPs. We saw evidence of completed audit cycles.

The practice manager and GP partners demonstrated leadership in their governance arrangements as they used the information from incidents and significant events to minimise risk by identifying trends and themes that may affect care and service quality.

Leadership, openness and transparency

Team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity to discuss issues directly with the GPs or practice manager regularly and were happy to raise issues at team meetings.

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

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

The practice had gathered feedback from patients through complaints, and the patient participation group (PPG). The PPG had representation from various population groups; including young people, those of working age and the elderly, seven ethnic backgrounds and a mix of male and female patients which reflected the practice's patient population. The PPG had carried out patient surveys, met face to face and communicated electronically. We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from the surveys were available on the practice website. The last patient survey undertaken identified a number of improvements such as how to address the issue of missed appointments and the impact that had on other patients who could not get an appointment. The survey also identified improvements that were needed in the way the practice provided patient information on noticeboards in the waiting room.

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

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and support. We saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and development.

The practice had completed reviews of significant events and other incidents and shared these with staff at meetings or discussed informally as appropriate to ensure the practice improved outcomes for patients. For example staff had the opportunity to contribute to discussions about a significant event when a GP had been unable to gain access to a patient's home. Staff worked together to devise a protocol and ensured and actions were taken to prevent a recurrence of the incident.