

# Dr Rogers and Partners

## Quality Report

The Baffins Surgery, St Cuthberts Church, Hayling Avenue, Portsmouth, PO3 6BH.

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

### Ratings

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

# Summary of findings

## Contents

### Summary of this inspection

	Page
Overall summary	2
The five questions we ask and what we found	4
The six population groups and what we found	6
What people who use the service say	8
Areas for improvement	8

### Detailed findings from this inspection

Our inspection team	9
Background to Dr Rogers and Partners	9
Why we carried out this inspection	9
How we carried out this inspection	9
Detailed findings	0
Action we have told the provider to take	21

## Overall summary

### Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Baffins Surgery, St Cuthberts Church, Hayling Avenue, Portsmouth, PO3 6BH on 27 January 2015. Overall the practice is rated as good.

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 all population groups. It required improvement for providing safe services.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks, chaperoning and health and safety.
- 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.
- Clinical data officers were responsible for managing patients who repeatedly attended accident and emergency departments and supported them to access services in the community.
- 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.
- Suitable systems to manage risk were not consistently put into place.

# Summary of findings

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

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

Importantly the provider must

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff that chaperone patients have appropriate risk assessments or criminal records checks in place.
- Ensure suitable systems are in place to manage risk to patients, in particular Legionella

The provider should:

- Sharps bins should have the lids secured
- Systems to ensure all nurses have their annual registration completed with the Nursing and Midwifery Council
- Fire drills were carried out should be documented

**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?

The practice was rated as requires improvement for providing safe services as there were some areas where improvements were needed. These included recruitment checks and health and safety checks. 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.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and suitable 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 for patients.

Good



### Are services caring?

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 were involved in decisions about their care and treatment. Accessible information to help patients understand the services was available. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Good



### Are services responsive to people's needs?

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. Patients said they could 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. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Good



# Summary of findings

## Are services well-led?

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

Good



# 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

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 provided a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. For example, home visiting for older patients' chronic disease management and pastoral care.

Good



### People with long term conditions

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

Good



### Families, children and young people

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. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good



### Working age people (including those recently retired and students)

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

Good



# Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. Extended hours appointments were available to book during the evening.

## **People whose circumstances may make them vulnerable**

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

**Good**



## **People experiencing poor mental health (including people with dementia)**

The practice was rated as good for people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.

**Good**



# Summary of findings

## What people who use the service say

Patients completed CQC comment cards to tell us what they thought about the practice. We received two comment cards; one respondent stated they were satisfied with the service, but the other respondent was less satisfied. They had arranged a same day appointment, which are allocated in hourly slots, they were unhappy that they had to wait to be seen.

We spoke with seven patients told us that if needed they were able to see a GP or nurse on the same day, but there was usually a wait once they arrived at the practice.

The national patient survey showed that 85.7% would recommend the GP practice to others. 78.4% of patients who responded described their overall experience of the practice as fairly good or good.

## Areas for improvement

### Action the service **MUST** take to improve

- Ensure recruitment arrangements include all necessary employment checks for all staff.
- Ensure all staff that chaperone patients have appropriate risk assessments or criminal records checks in place.
- Ensure suitable systems are in place to manage risk to patients, in particular Legionella

### Action the service **SHOULD** take to improve

- Sharps bins should have the lids secured
- Systems to ensure all nurses have their annual registration completed with the Nursing and Midwifery Council
- Fire drills were carried out should be documented

# Dr Rogers 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 specialist advisor and practice manager specialist advisor.

## Background to Dr Rogers and Partners

Dr Rogers and Partners, also known as Baffins Surgery is situated at The Baffins Surgery, St Cuthberts Church, Hayling Avenue, Portsmouth, PO3 6BH. The practice has approximately 8700 patients registered with it. The male to female patient ratio is approximately 50%. The age range of patients is in line with national averages.

There were a total of seven GPs working at the practice two of whom were male and five of whom were female. Between them they provided a total of 4.75 whole time equivalent staff (WTE). The GPs were supported by a team of nurses who provided a total of 2.66 WTE; a practice manager and assistant practice manager who provided 1.8 WTE. In addition there were three health care assistants who provided 1.09 WTE. There was an administration team who provided 12.46 WTE.

The practice has opted out of GP out of hours services which are provided by Portsmouth CCG via the 111 service.

## 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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 27 January 2015. During our visit we spoke with a range of staff and spoke with patients who used the service.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included practice policies and procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices website.

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

- Is it safe?

# Detailed findings

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

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

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

# Are services safe?

## Our findings

### Safe track record

The practice had a system in place for reporting, recording and monitoring significant events. The practice was able to demonstrate the process for recording incidents. 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. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. Records we viewed confirmed this. An example seen related to a delay in informing a GP of an urgent blood result. As a result of this a GP carried out a home visit and arranged for the patient to be admitted to hospital for further treatment.

### 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 significant events that had occurred during the last year and we were able to review these. Significant events was a standing item on the practice meeting agenda and a dedicated meeting was held to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

National patient safety alerts were disseminated by email to practice staff and information on learning was shared. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. An example included actions needed following a review by a pharmacist from the clinical commissioning group (CCG) who visited weekly. They had carried out a visit to the practice and noted that errors with prescriptions had been made by an external pharmacy service. A record of all incidents with this particular pharmacy had been made and shared with the CCG for further action.

### 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. The practice had policies on safeguarding children and vulnerable adults, which included information on types of abuse, and contact details of relevant agencies.

Staff at the practice had received 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. Clinical data staff supported the work of the lead GP and identified patterns when summarising notes and gave this information to the lead GP to act on if needed.

Safeguarding was a standing agenda item on the monthly clinical meetings and other health professionals were involved with these meetings if needed.

A chaperone policy was available in the practice. Nursing staff and health care assistants acted as chaperones and a log was maintained, which included space for the chaperone to make comments on the examination if needed. On occasion reception staff acted as chaperones. We found that not all staff, including clinical staff, acting as chaperones had a risk assessment in place to determine whether they needed a criminal records check carried out via the disclosure and barring service (DBS). Staff said they had received specific training. (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.)

### Medicines management

Nurses and the health care assistant administered vaccinations, such as for influenza, using directions that had been produced in line with legal requirements and national guidance. The practice had designated staff to manage repeat prescription requests. Protocols were followed to ensure the medicines were still relevant and necessary. 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.

There were suitable systems in place for managing and monitoring medicines held within the practice. Vaccines

# Are services safe?

were stored in specialist fridges and the temperatures were monitored regularly and recorded, we found that these were within safe limits of between two and eight degrees centigrade.

The practice received a visit each week from a pharmacist employed by the clinical commissioning group. They provided support and advice to the practice on managing prescriptions and maintaining cost effective prescribing, in line with national guidance.

## 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 we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All clinical staff received infection control training and annual updates. Infection control practice was discussed at monthly meetings with nursing staff. An annual audit had last been completed in 2013 by an external infection control nurse and the practice achieved 100% and some recommendations were made such as changing curtains every six months. This had been put into place. A further audit had been planned, but the infection control lead for the practice was not available due to illness, so would be undertaken when they returned to work.

An infection control policy and supporting procedures were available for staff to refer to, but this had not been updated or reviewed since 2012. The practice indicated that the infection control lead would carry out this piece of work when they returned to work. We saw staff had sufficient supplies of personal protective equipment, such as gloves and aprons. Systems were in place to dispose of clinical and general waste. Supplies of liquid hand soap, hand cleansing gel and paper towels were available by sinks for staff to use.

The practice did not have systems in place for the risk management of Legionella, a term for particular bacteria which can contaminate water systems in buildings.

## Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments

and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure measuring devices and the fridge thermometer. Calibration is where measuring equipment is tested to ensure it measures accurately.

## Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, satisfactory conduct in previous employment, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However, this information was not consistently gathered prior to a member of staff starting employment at the practice. For example, the majority of files did not have evidence of satisfactory conduct in previous employment and DBS checks had not been carried prior to a member of staff starting work. We looked at the staff handbook and found that staff were not requested to inform the practice if they had any cautions or convictions after they had been appointed. The practice manager said that information from staff had been requested to complete their DBS checks, but this had not been forthcoming.

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

Arrangements were in place to check that nursing staff were registered to practice, but these were not robust enough to ensure all nurses' registrations were current. The practice had not identified that a nurse's annual registration had lapsed prior to the Nursing and Midwifery Council informing them. The nurse had completed their re-registration process.

## Are services safe?

Locum GPs employed by the practice had appropriate checks carried out prior to working at the practice. These included a check on the performer's list. This was to ensure they were registered to practice.

### **Monitoring safety and responding to risk**

The practice had systems in place for monitoring safety and responding to risk, but these were not consistently put into place. Fire drills were carried out, usually as a result of the fire alarm being sounded, but were not documented. We saw sharps boxes, for the collection of used needles, prior to disposal, did not have their lids firmly secured and this posed a risk of injury.

### **Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (Automated external defibrillator – a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation

and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest and anaphylaxis. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A Emergency Responses Plan was in place. This had which had been reviewed in January 2015 and provided guidance on a range of emergencies that may impact on the daily operation of the practice, Risks covered by the plan 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.

# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

Patients' needs were assessed and treatment was delivered in a way which followed national standards and guidance. Patients confirmed that they received an assessment of their symptoms before GPs and nurses recommended treatment. Nursing staff at the practice were responsible for patients' chronic disease management, for example diabetes and asthma.

The practice used a software system that had assessment and treatment templates based on best practice guidance. 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. Information was discussed at practice meetings and current guidance was disseminated to staff. 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.

Patients who were diagnosed with long term conditions, such as, asthma and chronic obstructive pulmonary disease, (COPD is a condition which causes breathing difficulties), had care plans in place detailing the care and support they needed. The practice had a higher than national incidence of patients with COPD and were working with the clinical commissioning group to reduce this. The practice had recognised that there was a higher than average incidence of patients with diabetes. They had employed a practice nurse, who was the lead for diabetic care, and was able to start patients on insulin, a medicine used to control their condition.

The practice undertook audits of the referral rates to secondary providers, such as hospitals, to see whether they were effective and appropriate. Audit showed there was a low number of referrals which indicated that patients' needs were effectively managed in the primary care setting and the community. Referrals made by locum GPs were routinely audited to ensure they were effective and relevant.

### Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits. Clinical data officers were responsible for managing patients who repeatedly attended accident and emergency departments and supported them to access services in the community.

Information from the quality and outcomes framework (QOF), a national performance measurement tool, showed that the practice achieved 98.5% in its QOF results, which was slightly higher than the practice average across England. Specific areas where the practice achieved above the national average for QOF areas included: patients who were diagnosed with diabetes who had received the flu vaccine; and patients with diabetes who had a received a foot examination in the preceding 12 months.

The practice had a system in place for completing clinical audit cycles. We saw examples of these, which included one on urology referrals to the local hospital made by the practice. The audit focused on whether these referrals were relevant and made in a timely manner in accordance with local guidance. Another audit was carried out by an external provider and focused on prescribing for osteoporosis (a bone thinning condition); results from this showed that improvements had been made in prescribing the most effective medicine.

GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date.

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

### Effective staffing

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

# Are services effective?

(for example, treatment is effective)

Those with extended roles, such as supporting patients with asthma and diabetes were also able to demonstrate they had appropriate training to fulfil these roles. All staff had annual appraisals that identified learning needs from which action plans were documented.

GPs were up to date with their yearly continuing professional development requirements and had been revalidated or had a date for revalidation. Every GP was 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. Other staff who worked in the practice received an annual appraisal; learning needs were identified and planned for. Staff said they found this process was useful and they considered their training needs were met.

## **Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held weekly meetings with other health care professionals such as the palliative care team and district nurses. Care and treatment of patients receiving end of life care were discussed and outcomes were communicated to relevant professionals via email. The practice also used these meetings to discuss patients with complex needs, for example those with multiple conditions. These meetings were attended by a community matron as well as staff from the practice and decisions about care planning were documented in a shared care record.

## **Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system and said they were able to use it easily and there was scope for adding information when needed. Paper communications, such as those received from hospitals, were scanned and saved into the system on the individual patient record.

## **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. A nurse told us about patients who had learning disabilities and said that they were aware of those patients who lived independently and what support the patient needed to make a decision.

When interviewed, staff gave examples of how patients' best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all immunisations a box had to be checked on the patient record to show that this had been obtained from either the patient or their parent if it was a child who was unable to consent.

## **Health promotion and prevention**

There was a health promotion notice board situated in the waiting area. We saw this had information on contraception, shingles and alcohol consumption. Staff said they provided patients with information leaflets during their consultations.

The practice offered new patient checks when a patient first registered with them. They also offered NHS Health Checks to all its patients aged 40 to 74 years. The practice offered a full range of immunisations for children, NHS

## Are services effective? (for example, treatment is effective)

travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was above average for the clinical commissioning group.

GPs said there were various support services in the area which they were able to refer patients to, or patients were able to self-refer. For example, exercise classes, voluntary support organisations and adult education classes.

# 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, a survey of patients undertaken by the practice's patient participation group (PPG). 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 78% of patients rated the practice as fairly good or good. The practice satisfaction scores on consultations with doctors and nurses showed that 84% of practice respondents said the GP was good at treating them with care and concern. There were 92% of patients that said nurses treated them with care and concern.

Patients completed CQC comment cards to tell us what they thought about the practice. We received two comment cards; one respondent stated they were satisfied with the service, but the other respondent was less satisfied, they had arranged a same day appointment, which are allocated in hourly slots, and they said they had a long wait on arrival at the practice to see a GP.

Patients told us that if needed they were able to see a GP or nurse on the same day, but there was usually a wait once they arrived at the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting

rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk.

### **Care planning and involvement in decisions about care and treatment**

Patients said their health needs were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive.

### **Patient/carer support to cope emotionally with care and treatment**

Patients considered that support was provided by the practice to cope emotionally with care and treatment. Patients receiving palliative care were reviewed with other members of the multi-disciplinary team and the practice's end of life care register was accessible to out of hour's providers. Patients were able to contact the palliative care team and meet with them.

Patients who were carers or cared for were known to the practice and appropriate support was given.

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

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

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). These included telephone access to the service.

GPs in the practice said they knew older patients well as this population group was stable and had been registered at the practice for a number of years. Patients who lived in care homes had medicine reviews carried out in conjunction with a pharmacist, to ensure medicines were appropriate and relevant. In addition the practice met with a multidisciplinary team of health professionals to discuss patients at risk and those with complex care needs. For example, through their established links with the mental health team and dementia care nurses. Patients who had a learning disability were offered longer appointments and if needed these were in the patient's home.

### Tackling inequity and promoting equality

The practice was able to access sign language and foreign language interpreters when needed. The practice had links with a local children's charity and could signpost patients to the charity for support. The practice was aware of the demographics of the area in which they were situated and made appropriate arrangements to manage health care needs. For example, there was an area of social housing with single parent families who needed emotional as well as health support.

The practice had been adapted to meet the needs of patients with disabilities there were accessible toilets and baby change facilities.

### Access to the service

Appointments were available between the hours of 8.20am to 6pm on Mondays, Wednesdays, Thursdays and Fridays.

Appointments were available on Tuesday between the hours of 8.20am and 12.30pm and from 2pm to 6.30pm. Extended hours appointments were available on Tuesday evening and Thursday mornings. These consisted of nurse appointments and GP appointments. The practice ran a walk in same day service between 9.30am and 10.30am and 2.30pm to 5pm each day. Telephone appointments were also available throughout the day.

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.

Longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said 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.

### Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice. We sampled the complaints records and found that complaints were investigated and resolved as far as possible to the complainant's satisfaction. Learning points as a result of complaints were discussed at clinical meetings and recorded on the practice's computer systems. Information on how to make a complaint or comment was available in the practice and on its website.

# 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 gave a presentation at the start of our inspection and stated that their vision and values were to provide patient centred care and they were proud of the fact that many generations of a family were registered with the practice.

The practice was undertaking the Productive General Practice assessment. (This is an assessment of the practice as a whole and involves all staff members and covers areas such as work/life balance; decision making, time management and goal setting.)

Staff said that they were aware of the vision and values of the practice and found the Productive General Practice workshops valuable and they had highlighted areas where improvements were needed and they were working as a whole team to make these improvements.

### Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP lead for safeguarding. All staff members were clear about their roles and responsibilities. They all said they felt valued, well supported and knew who to go to in the practice with any concerns.

There were suitable systems in place to manage risks associated with health and safety. For example, a fire risk assessment and risk assessments for moving and handling. These were reviewed and changes made when needed to minimise risk.

Staff were aware of the need to protect patients' information and maintain confidentiality. There were systems in place to dispose of confidential waste and computer systems were password protected. GPs said that their rooms were locked when not in use.

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

maintain or improve outcomes. The practice had an on going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken.

One of the partners was a member of the clinical commissioning group and another was the safeguarding lead for Portsmouth. Both these GPs shared information on best practice with staff at the practice.

The GPs and managers attended an away day once a year to discuss how the practice was performing and concerns and plans for the forthcoming year. This included looking at staffing levels and holiday arrangements. The away day was facilitated by an external person.

### Leadership, openness and transparency

Staff told us they found the leadership at the practice was visible and accessible. They told us that there was an open culture which encouraged the sharing of information and learning. Areas that the practice was performing well in included putting patients at the centre of their work, support from colleagues and good team working. Areas for improvement included being fully involved in decision making; taking ownership of work and low staff morale. Actions were being taken to address these concerns as part of the Productive General Practice assessment.

Administration and reception staff found that they could communicate with other teams such as GPs and nurses. They said that managers were accessible and were able to go to GPs with any concerns. We found that support had been given to reception staff to assist in situations where they were subject to inappropriate behaviours by patients, such as verbal abuse.

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

The practice had gathered feedback from patients through: patient surveys, comment cards and complaints received. The practice had an active patient participation group (PPG) and we met with two members of the group.

The PPG produced a report in March 2014 which had priority areas for action agreed with the practice. These included monitoring of waiting times, online access for patients and telephone access.

The PPG met three times a year and monitored their action plan. A member of the PPG said that the annual survey was written by the group for patients and agreed with the GPs.

# Are services well-led?

Good 

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

They considered the practice listened to and acted on suggestions made. GPs regularly attended the PPG meetings. The PPG said there had been an improvement in the times patients waited to get through when they telephoned the practice due to the installation of more telephone lines. The PPG met with other PPGs in the city to share ideas.

The practice gathered feedback from staff through staff meetings, appraisals and discussions. Staff said they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff said they felt engaged and involved in the practice to improve outcomes for both staff and patients. They said GPs and the practice manager were responsive and listened to their ideas and took action when needed.

## **Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular

appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice and currently had one GP trainee with them. The GP trainee said they were always supported, supervised and considered they were part of the team.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients.

Nursing staff said they had had some issues with length of appointment times with insufficient time to complete patient records and availability of appointments, but this was being managed better by the practice. They anticipated that this would allow them sufficient time to maintain records.

This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers</p> <p>We found that the registered person had not carried out appropriate checks prior to staff commencing employment at the practice. This was a breach of regulation 21 of the Health and Social Care Act 2008 (Regulated Activities) regulations, which corresponds to regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.</p> <p>How the regulation was not being met:</p> <p>The provider did not have suitable policies and procedures in place to ensure that all required information was obtained prior to a member of staff commencing work at the practice.</p> <p>Regulation 21 (a) (b)</p>
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision</p> <p>We found that the registered person did not have suitable systems in place to identify and manage risks. This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) regulations, which corresponds to regulation 17 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014.</p> <p>How the regulation was not being met:</p> <p>The provider did not have suitable systems in place to identify, assess and manage risks relating to the health, welfare and safety of patients and staff.</p> <p>Regulation 10 (1) (b)</p>