Portishead Medical Group

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 Portishead Medical Group on 26 February 2015. Overall the practice is rated as good.

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

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed..
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a GP, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice included EMIS mobile as part of its information technology system to enable access to patient's records during home visits.
- The practice had a leaflet 'Your health record - protecting your information' that was available in braille.

Summary of findings

- A local carer's group held regular drop in sessions in the practice.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted upon.

We saw several areas of outstanding practice including:

- The practice used an easy read format letter with symbols to communicate appointments for patients with learning disabilities.
- The practice provided a range of educational sessions for patients including evening meetings.

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. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and relevant training planned to meet these needs. 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 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. 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. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. There was learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their

Summary of findings

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 upon. The patient participation group (PPG) was active. Staff had regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. 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 older people in its population and had a range of enhanced services, for example, in dementia care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

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

Working age people (including those recently retired and students)

Good

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

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients with a learning disability. It had carried out annual health checks for people with a learning disability. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). 99% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia. The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations.

Summary of findings

What people who use the service say

We spoke with nine patients who described the practice as warm and welcoming. They told us they were always respected and staff in the practice cared about them. The receptionists were described as very polite and all other staff, were described as extremely helpful.

Patients told us staff took time to communicate and treatment options were discussed. Some patients said they were well looked after and others described a wonderful service. Some patients spoke about long waiting times in the practice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed comments cards and the majority of comments were positive and complimentary. Two patients who referred to problems getting an appointment made positive comments about the way they were treated. One patient referred to the improved appointments booking system. A patient told us they had to wait in the practice to be seen whilst another told us they were always seen on time.

In the comments cards patients referred to the service as being 'excellent', 'fantastic' and 'top-class'. Some patients described being treated with respect and feeling valued by staff in the practice. Patients made comments about the GPs, nurses and reception staff being caring, kind, helpful, supportive and cheerful. Patients told us they felt their privacy and dignity were respected.

We contacted a mental health service as part of the inspection. They told us there were numerous occasions when they had contacted the practice to discuss medicine changes, diagnosis and management. They also told us about face to face meetings when they met to discuss patients. They said they found the reception system to be efficient, the GPs attentive and compassionate.

Outstanding practice

The practice used an easy read format letter with symbols to communicate appointments for patients with learning disabilities.

The practice provided a range of educational sessions for patients including evening meetings.

Portishead Medical Group

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 two other specialists, a practice nurse and a specialist with experience and knowledge of practice management.

Background to Portishead Medical Group

The Portishead Medical Group is a partnership comprising of eight GPs. One is the executive partner and there is a partner and financial partner. The partners employ a general manager to oversee the day to day operations of the practice and they are supported by an assistant manager and administrative assistant. The partners employ five salaried GPs, a team of nurses including a lead nurse and two advanced nurse practitioners, medical administration team, secretaries and summarisers, reception team and an appointments co-ordinator. There are five male GPs and there are eight female GPs.

The practice is based in the Portishead Health Centre in Victoria Square, Portishead, North Somerset, BS20 6AQ. It provides services to the residents of Portishead and the neighbouring Portbury, Clapton-in-Gordano, Weston-in-Gordano and Walton-in-Gordano.

It is a large practice with a rapidly expanding population of older patients. There were 18,000 patients registered with the practice with 20% of these being aged 65 years or older. This was greater than the England average of 16% patients over 65. Most patients described themselves as white (98%) and 95% state their first language as English. The practice is in one of the least deprived areas of England. Both male and female life expectancy exceeds the England average by one year.

Compared to the England average there are a greater number of patients registered with the practice with long-standing health conditions (58% compared to 54%). A slightly lower number of these patient's daily lives are affected by the condition (47.9% compared to 49%).

The practice holds a general primary medical services contract providing treatment for patients who are ill, management of long term conditions such as diabetes and asthma and treatment of temporary patients who need urgent treatment. In addition it provides a range of other services. These include cervical screening, contraceptive services, vaccinations and immunisation including those for children and influenza vaccinations for patients who are vulnerable and those over the age of 65 years. The practice provides minor surgery, a drugs misuse service, 24 hour electrocardiogram and ambulatory blood pressure monitoring and NHS checks for those patients who are eligible.

Quality and Outcomes Framework (QOF) is the annual reward and incentive programme detailing GP practice achievement results. QOF is a voluntary process for all GP practices in England and was introduced as part of the GP contract in 2004. The most recent QOF information showed the practice achieved 99% of the total available points compared to the England average of 94%.

The practice provides training opportunities for trainee GPs and nurses.

Out of hours services are contracted to Brisdoc through the 111 telephone service.

Detailed findings

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.

How we carried out this inspection

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

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

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

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

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 26 February 2015. During our visit we spoke with a range of staff including the GP partners, salaried GPs, practice manager, nurses, reception and administrative staff and spoke with nine patients who used the service. During our visit we met with four members of the patient participation group.

We also contacted care homes where those who lived there received a service, contacted a charity who linked with the practice and made contact with North Somerset Clinical Commissioning Group and the NHS England area team.

We observed how people were being cared for and talked with carers and/or family members and reviewed the personal care or treatment records of patients. We reviewed 26 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts in addition to comments and concerns raised. For example there was an incident when a patient was discharge unsafely from hospital following a procedure. The practice responded to this by raising an incident form and reporting it to the hospital.

Updates from the National Institute for Health and Care Excellence (NICE) were circulated to staff by email and discussed in clinical governance meetings. Staff told us they signed to indicate they had read the guidelines.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw records were maintained of significant incidents in relation to clinical issues and non-clinical issues. For example we saw how the practice changed its arrangements for Stoma supplies following a trend noticed in reporting of patient concerns.

Staff were aware of the practice policy for reporting and recording safety incidents, concerns, near misses and allegations of abuse and knew there was a log of these events. There were separate accident and incident books for staff and patients. When patient safety alerts were received by the practice manager they were cascaded to staff by email and were raised by the GPs at practice meetings.

Significant events and complaints were reviewed at the quartery clinical governance meetings when events were considered and learning points were recorded. Those that were non-clinical were considered at separate meetings. If a significant event related to a specific member of staff there was a record maintained of discussion with the member of staff. The practice manager was the reporting lead person for significant events.

Where patients were affected by something that had gone wrong, in line with practice policy they were given an apology and informed of actions taken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Two of the GPs were the practice lead professionals for child protection and safeguarding vulnerable adults and had completed training to level 3 in child protection as required. They attended regular meetings with the Clinical Commissioning Group and one of the partners told us they shared information with other staff through presentations and notes of the meetings.

There were meetings every 3 months with the community health visitors to discuss children and vulnerable adults on the 'at risk' register.

Staff demonstrated they were aware of how to find information relating to child protection and safeguarding vulnerable adults. They were able to give examples of how they might identify that abuse was occurring such as a patient being clearly unhappy about being with someone. Some staff told us about the training they completed in relation to child protection and safeguarding vulnerable adults and demonstrated an awareness of their responsibilities, others highlighted they had yet to complete the on-line learning refresher training. Staff knew who the lead GPs were in this area. They told us they had never raised an alert.

Patients were able request a chaperone to be present during any consultation, examination or treatment. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during and of these procedures. The practice brochure explained that should a patient require a chaperone to be present they should request this in advance of their appointment. Patients knew they could have a chaperone if requested. One patient told us they were always offered a chaperone for intimate examinations.

Medicines management

Prescribing initiatives were identified by one of the GPs in collaboration with a pharmacist. When alerts were received

from the Medicines and Healthcare Products Regulatory Agency (MHRA) patient records were searched to identify those affected so the practice could amend the patient's prescription.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Staff ensured medicines were stored at the correct temperature by taking readings of the temperatures and recording their findings. We saw this was carried out for each of the four refrigerators in the practice. We checked immunisations and found them to be in date.

To maintain the cold chain for medicines, when new stocks arrived in the practice the reception staff took them to a nurse straight away. They were recorded as having arrived within a log book and put into the refrigerators.

We saw there was a protocol for the administration of influenza and pneumococcal vaccines to adults by healthcare assistants. It reminded staff they were required to sign the relevant patient specific directive for the vaccines they administered.

Controlled medicines were stored securely as required. There was a log book for recording stock balances held and a protocol for any medicines found to be missing.

There was a prescription security protocol. It outlined general security precautions, ordering and receipt of prescription forms, storage and their distribution and use. In addition there was guidance on the arrangements for prescriptions used for prescribing controlled medicines. We saw a GP signing for a new prescription pad and ensuring records were kept of security numbers. A record showed prescriptions were reconciled each week.

We saw the prescribing pads and medicines register for addiction management were kept locked away. One of the GPs explained these prescriptions were collected by the pharmacist and not the patient, for extra security.

The GPs did not carry medicines in their personal bags however there was a shared bag with medicines available for visits which we saw was kept in a locked cupboard in a locked room. In addition there were individual bags with equipment to catheterise, for resuscitation and treatment of asthma. One of the nurses ensured medicines were within their 'use by' date.

We spoke with a pharmacist who told us there was good liaison with the practice. They told us how patients would be able to get repeat prescriptions at short notice (same day) and how the pharmacy and practice worked together to make this happen for patients safety.

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 and up to date. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness of infection control. One patient said they felt the practice seemed "sterile".

In readiness for registration with the Care Quality Commission and to demonstrate compliance the provider installed new hand washing sinks and flooring in clinical areas.

The practice had an identified lead nurse for infection control. They had conducted an audit of arrangements in the practice on 3 February 2015. It showed there were arrangements for hand hygiene, appropriate measure were taken to minimise the risk of infection, safe disposal of sharp instruments and waste, arrangement for the protection of staff and safe handling of specimens for testing. We conducted an audit of infection prevention and control during the inspection using a similar audit tool. It verified the findings of the practice audit. Nursing staff knew who was the lead nurse responsible for infection control. They told us they received training in infection control and had an update on hand washing techniques.

Staff told us there was always enough personal protective equipment (PPE) and confirmed they were always able to access sanitising hand gel. They told us when re-useable equipment was used such as the blood pressure cuff they were wiped clean between use.

The practice had identified a lead person as clinical waste segregation officer. We saw waste management guidance displayed in clinical areas.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). There was a risk assessment for legionella completed by an external organisation in June 2014.

Good

Are services safe?

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We saw evidence of testing and calibration of this equipment.

We also saw the practice records which showed there had been regular servicing of the automatic doors and water coolers, boiler service and testing of the portable electrical equipment.

Staffing and recruitment

The practice recruitment policy set out the process to be followed in the recruitment of staff. There was a separate document relating to criminal records checks with the Disclosure and Barring Service (DBS). It outlined how all clinical staff and staff with financial responsibility would be required to have a DBS check that included a risk assessment to determine whether a 'standard' or 'enhanced' check was needed. A recruitment checklist was used to ensure all necessary checks were completed before employment commenced.

We looked at staff records for newly recruited and long standing staff. We saw application forms were completed and gaps in employment history were clarified. There were records of interview questions and responses. Two written references were obtained and staff signed a confidentiality agreement. Where appropriate the vaccination status of staff was in place along with criminal records checks with the Disclosure and Barring Service (DBS).

There was no system in place for ensuring up to date Nursing and Midwifery Council (NMC) personal identification numbers (PIN) were in place. However this was implemented during the inspection and we saw evidence of the NMC PIN and registration for all nurses employed at the practice.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff to keep patients safe. We saw the practice monitors staff levels and skill mix linked to demand. An example of this in practice was the recruitment of two advanced nurse practitioners.

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. We saw a robust business plan which was reviewed in February 2015.

The practice recognised its moral and legal duty to ensure, as far as reasonably practicable, the health, safety and welfare of employees and others who could be at risk of work they undertook at the practice. We saw an index of risk assessments that were stored on the practice computer system. They included assessments related to health and safety, infection control, control of substances hazardous to health (COSHH), slips trips and falls and violence.

Where a patient or their companions were violent or aggressive towards staff and the behaviour was not related to the patient's clinical condition their GP reserved the right to remove them from registration with the practice. Where this was the case the patient would be informed in writing of the reasons for the GPs decision.

We saw risk assessments were reviewed and kept up to date. The practice had identified a competent person and representative for health and safety.

Each month staff carried out a visual check of the premises to ensure all areas of the practice were safe. These included the reception area, offices, car park and kitchen along with fire safety, general safety, infection control and COSHH. The checks included the security arrangements, storage, condition of floors and electrical safety. Clinical areas were considered for general safety as there were routine checks of these rooms that were more in depth.

A fire safety risk assessment was completed by an external contractor. There was a map of the building outlining the different fire zones. We saw the training records for the eight staff who were trained as fire officers for the practice. The fire policy and procedure were displayed. Records seen showed weekly testing of the fire alarm system and servicing of equipment including the emergency lighting and portable appliances. We saw evidence fire drills were carried out.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies.

We checked the medicines and equipment for use in the event of emergency. There was a log book for each of these which showed they were checked monthly to ensure

Good

Are services safe?

medicines were in date and the equipment was functioning. When we looked at the medicines they were all in date, oxygen was in date and the automatic external defibrillator was functioning.

We saw staff received training in dealing with medical emergencies and resuscitation. Staff confirmed they had completed training in the management of medical emergencies and resuscitation as a whole team in September 2014.

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 meetings where new guidelines were disseminated. The staff we spoke with and the evidence we reviewed confirmed these actions were designed to ensure patients received support to achieve the best health outcome for them.

The GPs took lead roles in specialist areas aligned to the Quality and Outcomes Framework (QOF) such as diabetes, heart disease and asthma which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. A nurse told us how the shared policies and procedures were on the practice computer system which was easy to navigate and made them easily accessible.

One of the GP partners told us the practice was continually striving to improve the quality of service and maintain high standards of care. They said they strived for excellence and the delivery of evidence based medicine. They described how the management of poly-morbidity, where older people who had a range of long term conditions that interacted with each other, was developing within the practice.

National data showed the practice was lower than the England average for prescribing hypnotics, anti-bacterial prescription items and non-steroidal anti-inflammatory medicines. It was slightly above the England average for the prescribing of certain antibiotic medicines.

Nurses told us about their special interests in diabetes management and asthma. There were specific clinics held to assist people with managing long term conditions. The practice nurses held diabetes management support groups.

Patients at risk and those with long term conditions were assessed and reviewed every six to twelve months. All were coded within the practice records system according to their health conditions and needs. The administration of medicines team coordinated annual reviews through the use of a diary system.

A patient with a life threatening condition told us if their referral to hospital had not been speedy following diagnosis by the GP they would not have survived. Several other patients echoed this when speaking about their spouse and how the “quick thinking” saved their lives or prevented paralysis. A temporary patient told us they had been referred to hospital and it had worked out well for them.

However, one patient told us their diagnosis had been slow and the prognosis was not good.

A patient told us how there had been a speedy response for glucose tolerance testing. The full process and reasons were explained to them and they felt fully informed.

The practice used an easy read format letter with symbols to communicate appointments for patients with learning disabilities. It had a picture of a stethoscope to show the letter was about the patient’s annual health check. The date of the appointment was then communicated using images of calendars and a clock. For patients with learning disabilities whoc communicated through the use of symbols the letter was beneficial.

Management, monitoring and improving outcomes for people

The practice had a system in place for completing clinical audits. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information was collated by the practice manager to support the practice to carry out clinical audits.

Audits being conducted at the time of our inspection included ensuring cancer exclusion in patients with deep vein thrombosis is adhered to, the prescribing of certain medicines to treat heart failure in older patients and a re-audit of croup management. In the last year there were audits related to infection control, prescribing anti-psychotic medicines to patients with dementia and a review of adult patients with congenital heart failure. We were told there were also audits looking at minor surgical

Good

Are services effective?

(for example, treatment is effective)

procedures, immunisation, splenectomy, cancer diagnosis, cases of clostridium **difficile** and contraceptive implants. There was also an audit relating to the prescribing of blood thinning medicine to patients with atrial fibrillation.

The practice prescribed medicines in line with the formulary provided by North Somerset Clinical Commissioning Group. This set out the recommended medicines groups for prescribing. One of the advanced nurse practitioners told us they used the British National Formulary provided by the British Medical Association as guidance when prescribing.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff, including receptionists. All newly appointed staff had an initial induction which included signing a confidentiality agreement, infection control and fire safety awareness. Staff told us they had sufficient training in order to perform their role.

The practice held personal development/ education sessions every three months for GPs and advanced nurse practitioners. Staff attended mandatory training in safeguarding, child protection, health and safety, fire safety and dealing with medical emergencies.

Staff told us about the various training they received. This included customer service training and prescription terminology for receptionists. The nurse prescribers had annual updates in prescribing and nurses attended training in infection control. One of the nurses told us about the training they had completed including insulin initiation for diabetes management, immunisations, manual handling and fire safety. Staff told us the practice made funding available for additional training such as the advanced nurse practitioner master's degree.

The nurse practitioners had identified GPs who mentored them. They told us they had monthly clinical supervision meetings. All staff had an annual appraisal.

We noted a good skill mix among the GPs with nine having additional qualifications in obstetrics and gynaecology, one in occupational medicine, one in pharmacology, one in geriatric medicine and one in reproductive medicine. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. Every GP is appraised annually and undertakes a fuller re-assessment called re-validation every five years. Only when validation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England.

Working with colleagues and other services

The practice worked with other service providers to meet 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. Patients could request test results by telephoning the practice.

A team of midwives were based within the health centre. Health visitors were based at a nearby care centre. There were regular meetings with the community teams to discuss all patients on the 'community ward' and patients nearing the end of life. The practice liaised with the hospice specialist nurse. We saw minutes of multi-disciplinary meetings. They showed the cases discussed and actions arising.

Where appropriate district nurses attended the meetings if they were involved in the cases.

Every three years the practice hosted mammography services to the people of Portishead and surrounding areas.

Childhood immunisation clinics were held and the practice nurses liaised with district nurses and health visitors regarding patients, when necessary.

We were told there was liaison between practice nurses and the community matrons, care connect and district nurses by text message, emails letters and telephone calls.

Patients completed CQC comment cards to tell us what they thought about the practice. One patient referred to the excellent liaison between the practice and hospital that was to their benefit. Another patient who had regular hospital appointments told us correspondence from the hospital to the GP was always followed up.

A local carer's group that worked with the practice confirmed they found the practice to be receptive to their presence and that they were provided with a quiet room to speak with carer's if necessary when they ran their drop-in sessions.

Good

Are services effective?

(for example, treatment is effective)

There were arrangements in place for repeat prescriptions to be collected by a number of local pharmacies in the area for patients' convenience.

The practice liaised with the voluntary hospital car service to arrange transport for appointments.

Information sharing

The practice had an identified Caldicott Guardian to protect patient information as required of all NHS services. This person ensured the Caldicott principles for the safety of patient information were adhered to in the practice. There was also a lead person for information governance who managed information systems and processes within the practice.

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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital. Staff reported this system was easy to use.

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

The practice had included EMIS mobile as part of its information technology system. It enabled a GP to view a patient's entire records, electronically, when undertaking home visits. They were also able to enter notes contemporaneously so that full information could be recorded into the patient's notes.

One of the practice nurses told us how they ensured patients felt involved in decisions about their care. They said they gave support, information and guidance to help people understand, listened to the patient's views and repeated the treatment before proceeding.

Nurses held structured information folders that enabled them to pass on information about various conditions. They said they also downloaded NHS information from the practice computer system.

We looked at the practice website. It provided a wide range of information about the services provided in the practice including details of the monitoring and treatment of long term conditions such as asthma and diabetes. There was information about pregnancy and the support available from midwives, self-help for common ailments and support for carers.

A seasonal newsletter informed patients, staff, other professionals and visitors about practice developments. The winter edition provided information about changes affecting patients such as, a GP's unavailability due to a sabbatical and changes to the practice website. In addition changes were included in the free magazine sent to businesses and households in Portishead.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Staff demonstrated an understanding of capacity to consent to treatment. The practice consent policy stated 'Patients have a fundamental legal and ethical right to determine what happens to their own bodies. Valid consent to treatment is therefore absolutely central in all forms of healthcare'.

The policy specified written consent was required for ear syringing and minor surgery and gave guidance to staff for when patients were unable to give consent and best interest decision making on a patients behalf. For patients who lacked capacity to make decisions the district nurses liaised with their carer to arrange and carry out health checks.

Patients with learning disabilities and those with a diagnosis of dementia were supported to make decisions through the use of care plans which they were involved in agreeing. There were 12 staff within the practice who were signed up with the Department of Health as 'Dementia Friends'.

There was a specific policy relating to consent to treatment and confidentiality in patients under 16 years of age. Staff we spoke with were aware 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.

Good

Are services effective?

(for example, treatment is effective)

One of the patients we spoke with attended with their parent. The parent had given consent for staff to speak with the child directly. Other patients confirmed they gave verbal consent to treatment. A nurse told us they always asked for patient consent in advance of treatment.

If a patient refused a particular plan of treatment their needs and wishes were respected. One of the nurses told us they would explain why the treatment was important and if they still refused, for patient safety, they would inform all those involved in the patient's care.

Health promotion and prevention

One of the patients we spoke with told us the practice encouraged 'self-care' and they believed this led to the practice recognising if people requested an appointment they needed one. Other patients told us they were identified on the patient records system as a 'priority patient' and this worked well with them having continuity of care and provided easier access to appointments.

New patients would be registered with the practice but could request an appointment with the GP of their choice. The practice brochure explained that when registering a new patient would be offered a health check with the practice nurse, given a copy of the practice brochure and would be asked to complete a medical questionnaire.

The practice supported the NHS Health Checks programme. For patients between the age of 40 and 74 assessments could be carried out for their risk of developing heart disease, stroke and kidney disease.

Patients not already diagnosed with these conditions and no reason to present at the practice, with a suspicion they had the condition, were invited to attend an appointment with a nurse or nursing assistant for a consultation every five years. Annual health checks were available for patients over the age of 75 years.

There was a health education room within the practice. It had a range of health related leaflets and displays of information. There was a folder in the practice waiting area. It contained a wealth of information about health management, addictions counselling and support services. In addition there was information about local services available; the NHS Patient Advice and Liaison Service (PALS) and getting help with health costs.

The practice provided a range of educational sessions. These included evening meetings, a diabetes forum and providing practical teaching about allergic reactions (anaphylaxis) in a local school.

We saw feedback following an evening men's health event held in October 2014. The majority of respondents to a survey thought it was informative, presentations were clear and the question and answer session was useful. Patients who responded to the survey suggested further events should include stress management, managing chronic conditions and coping with bereavement. The 'general update' sent to staff from the practice manager on 6 February 2015 showed the next evening event was to look at allergies including asthma, eczema and hay fever.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included the national patient survey (2013/14). It showed 85% of patients who responded to the survey indicated the last time they saw or spoke with a GP; the GP was good or very good at involving them in decisions about their care. This was greater than the England average of 82%. Similarly, there was a higher number of patients who indicated their experience with a nurse was greater than the England average of 85%, being 92% for this practice.

The Friends and Family test results for the practice scored the practice as 4.7 out of 5 patients would recommend the practice to family and friends.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 26 completed comments cards and the majority of comments were positive and complimentary. Two patients who referred to problems getting an appointment made positive comments about the way they were treated. One patient referred to the improved appointments booking system. A patient told us they had to wait in the practice to be seen whilst another told us they were always seen on time.

In the comments cards patients referred to the service being excellent, fantastic and 'top-class'. Some patients described being treated with respect and feeling valued by staff in the practice. Patients made comments about the GPs, nurses and reception staff being caring, kind, helpful, supportive and cheerful.

Patients told us they felt their privacy and dignity were respected. Staff and patients told us 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.

There was a member of staff designated as the dignity and respect officer. Patients' rights were outlined in the practice brochure. These included being treated with respect and courtesy and to have privacy, confidentiality and dignity respected.

Staff told us they competed online training in equality and diversity.

The reception team was made up of 17 staff who worked the equivalent of6 full time employee hours. There were always two receptionists who worked at the reception desk with three others located in a private area for taking telephone calls answering queries and to give test results. We heard reception staff being polite and friendly during telephone conversations and in face to face communication with patients.

We noted there was background music playing in the waiting area. The practice felt this enhanced confidentiality at the reception desk.

One of the staff told us they felt this to be a caring practice with good relationships with patients. They said there would rarely be an occasion when a patient would leave the practice with staff having done nothing for them. They included giving advice and an appointment time in this.

One patient we spoke with told us they had concerns about their treatment, had met with the GP concerned and found them to be very apologetic.

A patient told us how a GP had visited them at home after they were discharged from hospital.

Some patients told us how the GPs always remember personal things about them and asked about their family and pets. They said this meant they felt as if the GP knew them well.

Care planning and involvement in decisions about care and treatment

One of the GP partners told us emergency admissions and out-patient referrals were below average. They said to retain autonomy and provide patients with real choice they offered the 'choose and book' system within the patient's consultation. 'Choose and book' gave patients the opportunity to identify the venue for their first outpatient appointment and extended choice.

The provider held an enhanced service contract for providing services for patients with dementia.

Good

Are services caring?

For patients with poor mental health the practice sometimes referred them for cognitive behaviour therapy. If patients were prescribed anti-depressants there was always a pre-booked follow up appointment so their well-being could be monitored.

A parent told us they felt frustrated as their child saw a different GP each time they visited for recurring problems. They told us they had to repeat the child's history each time they visited.

Patient/carer support to cope emotionally with care and treatment

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.

One of the nurses told us they felt the practice was good at supporting people to cope emotionally with their care and treatment. They said they would signpost patients to support agencies and ensure the patient's GP was aware.

Notices in the patient waiting room and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

A local carer's support group ran an information drop-in at the practice once each month. It was specifically for carers and information and assistance was mostly given to those over the age of 65 years.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

Staff told us in order to be responsive to patients needs they listened to what patients had to say, brought them back for another appointment to monitor their health or signposted them to other agencies.

The practice provided a range of services to meet patients' needs. These included drop-in clinics for 24 hour blood pressure monitoring, phlebotomy, spirometry, post-operative care and echocardiogram (ultra sound screening of the heart). The latter of these was possible because the practice collaborated with a local charity to provide the equipment and deliver care to patients locally.

One of the GPs told us the GP team was supportive of colleagues. They said if there were a number of patients to be seen at the end of the day then all GPs would assist the GP allocated to urgent appointments.

The practice provided an annual review of medicines of patients in nursing homes jointly between one of the GPs and the Clinical Commissioning Group (CCG) pharmacist.

Patients could request repeat prescriptions in writing, by post or through the repeat prescription request box in the foyer of the practice. Alternatively they could register to request repeat prescriptions through the on-line service.

Minor surgery was available in the practice such as the removal of warts and there was a supply of liquid nitrogen to assist with this process.

When patients had tests carried out they were asked to contact the practice in three or four days to obtain the results. Patients were asked to avoid telephoning the practice early in the morning as this was the busiest time. If they wished they could call into the practice to obtain the results in person.

One of the patients we spoke with told us they found the evening appointments to be very convenient for them as they did not have to take time from work. A student also confirmed the convenience of evening appointments.

Several patients told us they felt the introduction of the nurse practitioner had eased the pressure on GPs. They said, having had a consultation with the nurse practitioner, this was a good service.

Tackling inequity and promoting equality

The building was accessed through automatic double doors and all consulting rooms and treatment room were at ground floor level. There was a wheelchair accessible toilet and a portable induction loop was available. There were two designated parking spaces for disabled drivers.

The practice used pictorial leaflets to advise patients with learning disabilities their appointment was due. We also noted there was a leaflet 'Your health record - protecting your information' available in braille. Patients who were partially sighted or blind were collected from the waiting room by the GP or nurse with whom they had an appointment.

The practice was registered and GPs were authorised to issue food bank vouchers for patients who found themselves in severe financial difficulty. This service could help some patients become less vulnerable.

Access to the service

Patients completed CQC comment cards to tell us what they thought about the practice. Two patients made comments about difficulty in obtaining appointments while others referred to the improved appointment booking system and being able to attain a same day appointment.

Entry into the practice was through electronically operated doors. All areas of the building were fully accessible and the reception desk was split level for accessibility. There was an induction hearing loop at reception. There was an automatic visual check-in screen for patients and a patient call system alerted patients to go to a specific consultation or treatment room. A patient told us they thought the touch screen arrival system was good.

One of the GP partners said they felt that being a large practice appointment access would always be a challenge. They told us they had repeatedly considered the issue and been proactive in managing patient access to the service. They told us their reviews had led to the employment of two nurse practitioners and a system where one GP carried out home visits and another provided an 'urgent surgery'.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open each week day from 8.00 am until 6.30 pm. There were evening surgeries on Tuesday and Wednesday for pre-booked appointments. These allowed those who worked during the day to see a GP without it interfering with their working pattern. Patients referred to the new later collection of blood samples which had made testing more convenient for them because they could have blood samples taken in their work lunch break. The practice used text appointment reminders for patients with a mobile telephone.

Face to face appointments or telephone consultations could be booked up to four weeks in advance either by telephone or on-line through the appointment booking system, for which patients were required to register.

There were on the day appointments available with the advanced nurse practitioner who was able to prescribe medicines. An 'urgent surgery' operated in the practice to provide a service for those patients with illness that needed to be dealt with on the same day.

The working pattern of each of the GPs was recorded in the practice brochure to enable patients who wished to pre-book an appointment with a specific GP to see their availability.

Appointments were set for ten minute intervals however patients could book a double appointment if they felt this was necessary. Home visits were available for patients who were unable to attend the practice.

When the practice was closed patients could telephone the 111 telephone service and obtain assistance from the out of hour's provider, Brisdoc. Information relating to this was displayed at the front entrance to the practice.

There was a GP lead professional for children and young people and they were steering the practice towards compliance with the Young People's Framework related to health outcomes.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible GP (registered manager) who supervised the complaints procedure and a nominated complaints manager (practice manager) who handled all complaints in the practice.

The complaints procedure was outlined within the practice complaint information leaflet which explained patients could contact the NHS Patient Advisory Liaison service (PALS) if they were unable to contact the provider. It also explained patients had the right to contact the Parliamentary and Health Service Ombudsman.

When complaints were made on behalf of a patient, the patient was required to sign to give their authorisation for the complaint to be made.

We looked at a summary of formal complaints for the last year. It showed there were 34 complaints received. Most complaints were discussed at significant event meetings and the practice differentiated between those that were of a clinical nature and those that were non-clinical. Of the 34 complaints 14 were of a clinical nature and two were not deemed to have any learning to be derived from them so were not discussed at the significant event meetings.

An analysis of complaints received by the practice in the period April 2013 to March 2014 showed 13 out of 29 complaints were upheld. Seven of these related to advice given by a GP, 19 were related to medical issues and three were classed as other.

Staff were aware of the complaints procedure and knew the practice manager handled all complaints. One of the staff told us how the nature of complaints and compliments were used as a means of learning.

The practice carried out an annual audit of complaints on line for the North Somerset Clinical Commissioning Group and NHS England area team.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and provide good outcomes for patients. The purpose of the practice was to provide patients with personal health care of high quality and to seek continuous improvement of the health status of the practice population overall. It stated it aimed to achieve this by developing and maintaining an effective and motivated practice, responsive to patient's needs and expectations reflecting the latest advances in primary health care.

We spoke with the administration team who were aware of the practice vision and strategy. They said patients come first and are always put first. Other staff we spoke with were clear about the vision for the practice.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop of any computer within the practice. We looked at eight of these and found they had been reviewed regularly.

The practice identified two GPs as clinical governance lead professionals and a clinical guidelines coordinator. Clinical governance meetings were held. They reviewed the previous meeting minutes to ensure any actions were completed. They included National Institute for Health and Care Excellence (NICE) updates, presentation of audit findings and educational updates. We were told these recently included updates relating to urology, dermatology and a review of anti-biotic prescribing. There had also been sessions in connection with research in primary care and an introduction to the Map of Medicine. Using the Map of Medicine, clinicians had instant access to locally customised pathways, centrally controlled referral forms and clinical information during a consultation. Integrated within the clinical workflow, healthcare professionals have relevant information at their fingertips and can save information directly to the patient's record.

We looked at the records of meetings held in September and November 2014. They included a review of the previous meeting minutes, NICE updates and review of significant events.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for the practice showed it was above the England average in all areas. The deputy manager monitored the QOF and gave the GPs action lists. For each area of the QOF there was a lead GP.

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. These included infection control arrangements, clostridium difficile infection, anticoagulation therapy and use of certain medicines including an audit of anti–psychotic prescribing in patients with a diagnosis of dementia.

One of the GPs was an academic GP and the practice was involved in their research project looking at topical emollients in the treatment of eczema and whether treatment of the condition, where the skin becomes inflamed and itchy, with antibiotics was beneficial.

Leadership, openness and transparency

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 lead GPs for child protection and safeguarding vulnerable adults.

The GPs took special interest in children's services, alcohol and drug services and research and were linked with external agencies such as the Clinical Commissioning Group.

We saw from records a range of meetings were held. These included twice yearly practice strategy meetings which included a review of the past year and the strategy for the future. The meetings considered changes to the GP contract and GP special interests. Practice meetings were held every two weeks when business issues were discussed.

The nursing team and administration team had individual meetings to discuss practice issues pertinent to them. A range of other meetings were held to ensure effective communication was maintained.

The practice manager communicated with staff by email through 'general updates'. We saw the most recent of these which showed staff were kept informed of developments.

The lead nurse told us they had an annual appraisal with the practice manager which involved obtaining feedback from other staff in the practice. As lead nurse they had been delegated the responsibility for the appraisal of other nurses.

Are services well-led?

Good

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

Staff told us they enjoyed working together and supported and supervised each other in their roles. They described a good team where there were clear roles and responsibilities. Staff said they felt valued and supported. They spoke of how management were considerate of practice staff and responsive to poor performance by providing support and supervision to help staff "get it right". One of the staff told us all of the GPs were approachable and supportive

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

The practice had a patient participation group (PPG). It was launched in April 2011 as a development of the existing patient group which was called 'Critical Friends'. As a 'virtual' group it shared information, provided feedback and opinions by email and undertook regular surveys. In addition some of the members of the PPG had meetings every three months to provide steering to the group. In March 2014 the virtual group had 98 members of which 63 were prepared to attend steering group meetings.

The PPG defined the questions for regular patient surveys and there was an additional survey that was conducted by an external agency. The PPG decided their survey should ask patients about the appointment system, practice environment, feedback about treatment received, information and other services available. Surveys were conducted in October 2013 and February 2014 and in total there were 962 responses.

Outcomes from the survey included an audit of waiting times and identification of where patients had to wait to see the GP, and a review of the reception rota to increase the number of staff available to answer telephones in the morning. Some respondents thought the receptionists were not empathetic and the senior receptionists were charged with promoting customer service.

We saw the minutes and action log of PPG meetings. They recorded full accounts of the topics discussed and actions arising from the discussions.

A patient told us they felt the practice listened to patients and the PPG. They said the PPG had influenced the decoration of the waiting area.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. Staff we spoke with confirmed they knew how to access the policy.

Management lead through learning and improvement

To ensure the practice was up to date with research one of the GPs was conducting studies into continuity of care and antibiotic treatment in infected eczema. There was further research into deep vein thrombosis (DVT) and croup.

Two of the GPs were trainers. The practice hosted GP training and provided clinical supervision to foundation GPs and GPs undertaking specialist training in years one and two. It also provided education supervision to specialist trainees in year three of their studies. A GP registrar described the practice as friendly. They spoke about the weekly tutorials they had and how they participated in joint injection appointments. They said they could ask any of the GPs for assistance and were able to discuss patients with complex health needs.

In addition the practice taught nursing students, medical students and paramedical staff to become treatment prescribers.

The practice offered interview support to local secondary school pupils wishing to become medical students.

The practice had arrangements which allowed GPs to take six month, self-funded, sabbaticals every 10 years. We were told one of the GPs had recently returned from New Zealand and another from Romania. These opportunities for development had a general benefit to the practice.