The Hanway Group Practice

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Hanway Group Practice on 20th 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. The practice is also rated as good for the six population groups which 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 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 named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- There was open access to the practice for patients who were residents at a local care home.

Summary of findings

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 appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

Summary of findings

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. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice 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 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 (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. The practice incorporated the gold standards framework for palliative care.

It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had an open access arrangement for patients who lived at a local care home. This meant they could turn up and be seen by a GP or nurse without the need for an appointment.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nursing staff had lead roles in chronic disease management such as diabetes and asthma and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed.

All patients had a named GP and a structured annual review to check that their health and medication needs were being met. For patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The practice had virtual ward multi-disciplinary team reviews of patients with long term health conditions.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Summary of findings

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. There was a named safeguarding lead for the practice and GPs and staff followed the Gillick competency checks to ensure that young people had the capacity to make their own decisions regarding their treatment.

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. This included offering extended hours appointments such as early in the morning and late in the evening as well as opening on Saturday mornings. Patients were also able to have telephone consultations.

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.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks and longer appointments for patients with a learning disability.

There was same day access for those who needed to see a GP or nurse.

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).

Summary of findings

100% of patients experiencing poor mental health were offered 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 about how to access various support groups and voluntary organisations including MIND. It had a system in place to follow up patients who had attended accident and emergency (A&E) departments where they may have been experiencing poor mental health.

Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients on the day of our inspection. All of them were very positive about their experiences of care and treatment at the practice.

All the patients we spoke with told us that their treatment was clearly explained to them and they were able to ask questions and make choices about their treatment or medicine. Patients said they felt there were enough staff and the staff had the right skills and experience to meet their needs.

We received three comment cards on the day of our inspection. All the comments were positive and told us that the practice was caring and compassionate. We reviewed data from the national patient survey which showed the practice was rated above the national average by patients who were asked if they were given enough time during their appointment by clinicians and their confidence and trust in the last nurse they saw. 84% of patients said they would recommend the practice and 94% of patients surveyed were able to get an appointment to see or speak to someone the last time they tried.

Outstanding practice

The practice had an open access service for patients at a local care home. Patients from this home were able to turn up without an appointment and be seen by a GP.

The Hanway Group Practice

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to The Hanway Group Practice

Hanway Medical Practice is a large inner city practice serving the health needs of approximately 11,550 patients in Portsmouth.

The practice team consists of five GP partners and a salaried GP who together work an equivalent of four and a quarter full time staff, a nurse practitioner, three practice nurses, three health care assistants an alcohol prevention advisor and a smoking cessation advisor.

The practice is a registered training practice with two GP trainers. This means that Registrars completing their final year of training are supervised before becoming fully qualified GP's.

GPs and nursing staff are supported by an administration and reception team and the practice manager.

The practice has two locations

2 Hanway Road, Portsmouth Hampshire PO1 4ND

81 Stubbington Avenue Portsmouth Hampshire PO2 OJD

The practice is registered to provide the following regulated activities:

- Diagnostic and screening procedures
- Family planning
- Maternity and Midwifery services
- Surgical procedures
- Treatment of disease, disorder or injury.

We inspected the practice at 2 Hanway Road. The opening hours at this location are Monday to Friday 8am to 6pm with early morning appointments available on Fridays between 7am and 8am.

Out of hours services are provided by Portsmouth using 111.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

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

Detailed findings

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with six patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice before and during our visit.

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 include:

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

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 as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example we looked at a record of one event where a patient became unwell in the waiting area and an ambulance was called .

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

The practice has weekly partner meetings and minutes showed that incidents were discussed in these meetings.

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 weekly practice partner meeting agenda and a part of this meeting was 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 also had monthly meetings and knew how to raise any issues for consideration at the meetings and they told us they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of staff who had dealt with an aggressive person who was not a patient. The practice arranged training for staff on how to deal with difficult people who come into the practice and changed the policy and procedures on access to toilets for patients. There had been no further incidents of this type since the new measures had been put in place.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. We also saw three examples where the practice had written to patients, given them a full explanation as to what went wrong and offered them choices of how to resolve the issue.

National patient safety alerts were disseminated and discussed by email and weekly meetings to practice partners and staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding adults and children. We asked members of medical, nursing and administrative staff about their most recent training. All of the staff we spoke with knew how to recognise signs of abuse, were aware of their responsibilities and knew how to share information by properly recording safeguarding concerns. All staff were aware of how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible and staff knew where these were located.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three and could demonstrate they had the necessary knowledge to enable them to fulfil this role. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern. All of the staff who were not safeguarding leads had been provided with appropriate role specific training in safeguarding.

There was a system to highlight vulnerable patients on the practice's electronic records. We saw information to make staff aware of any relevant issues when patients attended appointments; for example vulnerable adults and also children who may be subject to child protection plans.

Good

Are services safe?

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. The practice had carried out disclosure and barring service checks (DBS) on all clinical staff who acted as chaperones and had carried out an appropriate risk assessment on those who did not have DBS checks but still may carry out this role.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy. There was also a cold chain protocol for staff to follow in the event of a suspected failure of the refrigerator. The practice shared information from NHS England amongst all its staff concerning any issues regarding the storage of medicines.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, we saw discussions concerning the prescribing of Warfarin within the practice.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines.

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 and kept securely at all times.

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 staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed. We saw the most recent infection control audit from May 2014 that showed the practice was at 92% for infection control. This was up from 84% from the previous audit.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, all curtains used in the practice were disposable and were replaced every six months in treatment rooms and every 12 months in consulting rooms.

There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. We saw an audit that showed sharps handling and disposal was at 100%

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

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).We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Good

Are services safe?

Records showed that all clinical staff had been protected from the risk of Hepatitis B. The records showed date of vaccine, date of blood test, blood test results and when the vaccine was next required if the member of staff did not have lifelong immunity.

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 of November 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. This record showed the location of the equipment, the last service date, the service due date and the company that was responsible for servicing. Staff were aware of the processes to report faulty equipment.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

We looked at two staff recruitment files and saw evidence of job description, application form, two references, the staff handbook, photographic identification, a signed contract, confidentiality form and practice policy on chaperoning.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all 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. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. Patients we spoke with told us they felt there were enough staff on duty to meet their needs.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log and any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

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 (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient who had collapsed and that practice had learned from this appropriately.

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, anaphylaxis and hypoglycaemia. 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 business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of

Good

Are services safe?

the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of all the services supplied to the practice, such as water, electricity and gas and a list of local trades people including electricians and plumbers. A copy of this plan was kept at home by all the GPs.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Results of these fire drills were recorded and all staff were debriefed so that learning took place. Records showed the alarm was tested weekly and the fire extinguishers were checked on a monthly basis. instructions were clear for evacuation of the building.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners.

We saw minutes of practice meetings where new guidelines were disseminated and the implications for the patients were discussed. The staff we spoke with, and the evidence we reviewed, confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, 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. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP according to need.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of suspected illnesses such as dementia and also ensured patients with suspected cancers were referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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

Management, monitoring and improving outcomes for people

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.

The practice showed us examples of clinical audits that had been undertaken in the last three years. Three of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Some of the changes were reduced prescribing for cancer drugs, and improved outcomes for patients at high risk of strokes.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of anticoagulants. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for QOF in diabetes, asthma, chronic obstructive pulmonary disease (lung disease). This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance

Good

Are services effective?

(for example, treatment is effective)

of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, 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 used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question, such as Warfarin, and, where they continued to prescribe it, outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice was aiming to achieve the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register. The practice had also carried out an after death audit which showed that all three people who had expressed their wish to die at home had indeed done so. The audit clearly outlined what improvements in this area of patient care need to be made

The practice also participated in local benchmarking run by the clinical commissioning group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the percentage of patients aged 65 and older who had received a seasonal flu vaccination was similar when compared to other local practices.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the GPs with all of them having additional diplomas in specialist areas such as dermatology, coil fitting, prescribing and epilepsy.

All of the GPs were up to date with their yearly continuing professional development requirements and all had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. As the practice was a training practice, doctors who were training to be qualified as GPs offered extended appointments to patients and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, phlebotomy and spirometry. Those with extended roles or seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. The skill set amongst the nursing team was balanced to meet all the needs of the registered patients.

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

Good

Are services effective?

(for example, treatment is effective)

spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice held multidisciplinary team meetings on a six weekly basis to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several systems to communicate with other providers. For example, there was a shared system with the local out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice is currently in the process of upgrading its computer software in order to be able to have fully computerised patients notes and a better method of assisting with patient integrated care.

The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by April 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record, vision, to coordinate, document and manage patients' care. All staff were fully trained on the system. However, the practice is moving to a new system, TTP, in July 2015 as well as developing a new website.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All of 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. This included listing a patients wishes on whether they wished to die at home or in a hospital setting.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of 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 coil fittings and spirometry signed consent was obtained. Patient's consent was also documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way, for example those at risk of diabetes. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

Good

Are services effective?

(for example, treatment is effective)

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that all patients in this age group who took up the offer of the health check.were followed up if they had risk factors for disease identified at the health check and also how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all of them were offered an annual physical health check. The practice actively offered nurse-led smoking cessation clinics to patients who smoked.

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

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey undertaken in January 2015, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. The practice was also above average for its satisfaction scores on consultations with GPs and nurses. 93% of respondents to the GP patient stated that the last time they saw or spoke to a nurse, the nurse was good or very good at involving them in decisions about their care, the national average is 85%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All of these patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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 saw consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

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 and was shielded by partitions which helped keep patient information private.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident involving a patient that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 83% of practice respondents said the GP involved them in care decisions and 90% felt the GP was good at explaining treatment and results. Both these results were above average compared to national results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 93% of respondents to the Patient Participant Group survey said they had received help to access support services to help

Good

Are services caring?

them manage their treatment and care when it had been needed. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also 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.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service.

The practice had carried out an after death audit with bereaved families which showed that those patients who had wished to die at home were considered to have done so comfortably and in a planned way. The audit also highlighted areas that could be improved, such as maximising the support for families and patients during the end of life care process. There was an action plan in place for this.

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.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population.

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). For example, the practice changed opening hours and implemented late night and early morning appointments in response to the patient survey.

Tackling inequality and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Same day access was available to temporary residents and travellers

The practice had access to online and telephone language translation services and a hearing loop had been installed at reception

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

The premises and services had been adapted to meet the needs of patients with disabilities. This included step free access and wide doors and corridors to facilitate those who used wheelchairs

We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

There was an open access system in place for patients living at a local care home. All patients living at this home were given a card when they registered at the practice. This allowed them to present at the desk during surgery times to see a GP without the need for an appointment. This was introduced by the practice after patients explained they had to rely on carers or family members to assist them in getting to the practice and they were unsure of a time. Therefore, they could be seen whenever they received assistance to do so.

The practice told us this has resulted in less home visits, patients are happy with the service and GPs are able to see more patients at the practice.

Access to the service

Appointments were available from 8am to 6pm on weekdays. Appointments were pre-bookable on line, in person and by telephone. Routine appointments were bookable up to three weeks in advance. Same day appointments were available to book in person or on the telephone. Patients were able to get urgent same day appointments.

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 in the patient leaflet, on the website and on the main entrance door of the practice.

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. Home visits were made for those patients who needed one.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us they had moved to the area and needed to see a GP. They registered and were seen within one hour.

The practice's extended opening hours on Friday morning was particularly useful to patients with work commitments. This was confirmed by two patients we spoke with.

Listening and learning from concerns and complaints

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

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

We looked at 13 complaints received in the last 12 months and found all of these were satisfactorily handled. The complaint was dealt with in a timely way and the practice involved the complainant in the process, wrote an apology when necessary and provided the person complaining with informed options so they could decide how they wanted the complaint resolved. An example we saw is a person being offered a refund of part of their telephone bill for being held on the phone longer than was necessary. Even though an investigation showed there was an issue with the phone line.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. This was seen in the annual complaint report which listed the individual complaints and explained what steps had been taken to prevent similar complaints from happening again.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included plans to redevelop part of the surgery to create more space for patients and staff, to implement new computer systems to improve integrated care for patients and to create an alliance and federation of practices to improve health for patients in the Portsmouth area.

Some of the values the practice strived to achieve were to be empathetic, honest and courteous, to serve the community and improve health outcomes and to act confidentially, respect diversity and endeavour to meet patient's needs.

All of the staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures saw they had been reviewed annually and were up to date. All of the staff we spoke with were aware of were the policies were located and were familiar with their contents. Staff explained that they had discussions at team meetings about any changes in policy.

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 the senior partner was the lead for safeguarding. We spoke members of staff including nurses, reception and administration and they were all clear about their own roles and responsibilities and those of others. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

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

The practice had a system of carrying out clinical audits which it used to monitor quality and systems to identify where action should be taken. These included audits on diabetes, medicines, end of life care and health checks for people with learning disabilities.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as vaccine fridge failure. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. This included the business continuity plan where the practice had arrangement in place so they could continue to treat patients in the event that services were lost due to fire, flood or other emergency.

The practice held six weekly governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least weekly for GP partners and monthly for other staff. Staff told us that there was an open culture within the practice and they had the opportunity to raise issues at team meetings.

We were shown the staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and 94% of patients were able to get an appointment to see or speak with someone the last time they tried. We saw the practice had introduced early morning appointments in response to patient suggestions on the survey.

Are services well-led?

Good

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

The practice had an active patient participation group (PPG) which included representatives from the various population groups such as older people and families, children and young people.The PPG had carried out annual surveys and met twice yearly. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

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 several staff files and saw that annual appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was a GP training practice and has two GPs who are registered trainers. Registrars (Doctors completing their final year of training before becoming fully qualified GP's) work at the practice and are supervised. They are able to offer patients extended appointments.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. Examples included the confirmation of patient information to ensure test results were added to the correct record and the changing of working practices to ensure the continued safety of patients and staff.