Port View Surgery

Quality Report

Higher Port View
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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 undertook a planned, comprehensive inspection of Port View Surgery on 13 January 2015. Port View Surgery provides primary medical services to people living in Saltash and surrounding villages in Cornwall. At the time of our inspection there were approximately 6580 patients. The practice provides services to a diverse population and is situated in a town centre location.

The practice comprises of a team of five GP partners (three male and two female) who hold managerial and financial responsibility for running the business. In addition there is a salaried GP, four registered nurses and two health care assistants. An administration team and a full time practice manager are employed in the running of the practice.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The practice is rated as good. An innovative, caring, effective, responsive and well-led service is provided that meets the needs of the population it serves.

Our key findings were as follows:

There are systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events are recorded and shared with multi professional agencies and there is evidence that lessons are learned and systems changed so that patient care is improved.

There are systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients. According to data from the Quality and Outcomes Framework (QoF), which is the annual reward and incentive programme detailing GP practice

achievement results, outcomes for patients registered with this practice are above average for the locality. Patient care and treatment is considered in line with best practice national guidelines and staff are proactive in promoting good health.

The practice are pro-active in obtaining as much information as possible about their patients including carer status, family dynamics, dependency and any other outside influences which do or can affect their health and

Summary of findings

wellbeing. All the staff know the practice patients very well, are able to identify people in crisis and are professional and respectful when providing care and treatment.

The practice plans its services to meet the diversity of its patients. There are good facilities available, adjustments are made to meet the needs of the patients and there is an appointment system in place which enables good access to the service.

The practice has a clear vision and set of values which are understood by staff and made known to patients. There is a clear leadership structure in place, quality and performance are monitored and risks are identified and managed.

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. There were robust systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who used the practice. Patients we spoke with told us they felt safe. Information from the Clinical Commissioning Group (CCG) and the Local Area Team (LAT) indicated that the practice had a good track record for maintaining patient safety.

Staff took action to learn from incidents and made appropriate safeguarding referrals when necessary. There were appropriate checks to clarify that staff were suitable to work with vulnerable people. All the staff had been at the practice for a considerable number of years and locum staff were consistent. Significant events were recorded and shared with multi-professionals, including members outside the practice.

Are services effective?

Good

The practice is rated as good for providing effective services. Supporting data obtained both prior to and during the inspection showed there were systems in place to make sure the practice was effectively run. The practice had a clinical audit system in place and audits had been completed. Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services and strived to achieve the best outcome for patients who used the practice.

Supporting data showed staff employed at the practice had received appropriate support, training and appraisal. GP partner appraisals and revalidation of professional qualifications had been completed. The practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Good

The practice is rated as good for providing caring services. All the patients we spoke with during our inspection were very complimentary about the service. All the patients who completed a comment card in the weeks before our inspection were entirely positive about the care they received. We saw staff interacting with patients in a caring and respectful way.

Staff were motivated and inspired to offer kind and compassionate care and put significant effort in to providing care that took account of each patient's physical support needs and individual preferences.

Summary of findings

Patients were involved in planning their care and making decisions about their treatment and were given sufficient time to speak with the GP or nurse. Patients were referred appropriately to other support and treatment services.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. We found the practice had initiated many positive service improvements for their patient population. The practice had reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and the local clinical commissioning group (CCG) to secure service improvements where these had been identified. Patients reported good access to the practice and appointments were made available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs.

There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice was rated as good for being well-led. There was good leadership and a strong learning culture and the practice had a clear vision which had quality and safety as its top priority. The service effectively responded to change and encouraged its staff to bring suggestions for improvement. There was a clear set of values which were owned and understood by all staff and were evident in their behaviours. The team used their clinical audits, knowledge obtained from other sources and staff meetings to assess how well they delivered the service and made improvements where possible.

There was an open and honest culture and staff knew and understood the lines of escalation to report incidents, concerns, or positive discussions. All staff we spoke with felt valued and rewarded for the jobs they undertook and they were encouraged and trained to improve their skill sets. We found there was a high level of constructive staff engagement and a high level of staff satisfaction.

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 was rated as good for the population group of older people. The practice had a register of all patients over the age of 75 and these patients had a named GP. Patients at risk of an unplanned hospital admission had a care plan in place. Housebound patients were routinely visited so they could be given information and advice to prevent hospital admissions.

Care was tailored to individual needs and circumstances. There were regular care reviews involving patients, and their carers where appropriate. Treatment was organised around the individual patient and any specific condition they had.

The practice had a system to identify older patients and appropriately coordinated the multi-disciplinary team (MDT) for the planning and delivery of, for example, palliative care for older people approaching the end of life. This included working with a community matron for older patients in the community.

People with long term conditions

Good

The practice is rated as good for the care of people with long term conditions. The practice identified patients who might be vulnerable, including those with multiple or specific complex or long term needs and ensured they were offered consultations or reviews where needed. The staff at the practice maintained links with external health care professionals for advice and guidance about particular long term conditions, such as diabetes and asthma.

Patients with long term conditions had tailor-made care plans in place. Patients were pleased with the care they received for their long term conditions and were offered clinics at a time convenient to them for monitoring and treatment of conditions. These included diabetes, heart failure, hypertension, high cholesterol, renal failure, asthma and chronic respiratory conditions. The nurses took a lead role in particular conditions and attended educational updates to make sure their knowledge and skills were up to date.

Appointments were available for patients with asthma and chronic lung disorders. The practice used spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients. The practice also promoted independence and encouraged self-care for these patients.

Patients were supported with weight management and referrals to dieticians were made where appropriate.

Summary of findings

Specific appointments were made which supported and treated patients with diabetes; they included education for patients to learn how to manage their diabetes through the use of insulin. Health education about healthy diet and life style for patients with diabetes was provided.

Home visits and medicine reviews were provided by GPs, for patients with long term conditions who had been recently discharged from hospital.

The practice used a specific computerised patient record system allowing out of hours service providers to access information about specific patients, this helped promote continuity of care and treatment, providing a more seamless service for the patient. The practice's GPs and the out of hours service GPs were then aware of any treatment that had been given to patients with long term conditions, or those at the end of their life.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Parents we spoke with were very happy with the care their families received.

There were well organised baby and child immunisation programmes available to help ensure babies and children could access a full range of vaccinations and health screening.

The practice had effective relationships with health visitors and the school nursing team, and was able to access support from children's workers and parenting support groups. Systems were in place to alert health visitors when children had not attended routine appointments and screening. The practice referred patients and worked closely with a local family and child service to discuss any vulnerable babies, children or families.

Men, women and young people had access to a full range of contraception services and sexual health screening including chlamydia testing and cervical screening.

The practice is involved in a service called "Tic Tac". This is a shared initiative with other practices in the area. A GP and nurse from the practice held a lunchtime drop in service at the local high school. The clinic offers advice and treatment to young people.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of patients who were of working age or who had recently retired and students.

Advance appointments, including early morning and evening appointments were available twice a week to assist patients not able to access appointments due to their working hours. Saturday morning appointments were also available once a month.

There was a well-established patient participation group at the practice who demonstrated that they were constantly striving to recruit new members of working age.

Suitable travel advice was available from the GPs and nursing staff within the practice and supporting information leaflets were available. Pneumococcal vaccination and shingles vaccinations were provided for patients at risk, either at the practice during routine appointments or at weekends for patients who found it difficult to access the practice during office hours.

The staff took every opportunity to carry out health checks on patients as they attended the practice. This included offering referrals for smoking cessation, providing health information, routine health checks and reminders to have medicine reviews. The practice also offered age appropriate screening tests; examples included testing for prostate cancer and cholesterol testing.

Patients who received repeat medicines were able to collect their prescription at a pharmacy of their choice. The practice had an electronic prescribing system in place which sent the approved prescription directly to the chosen pharmacy. This was useful for patients who could not easily access the practice during office hours.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. There were no barriers to patients accessing services at the practice. Patients were encouraged to participate in health promotion activities, such as breast screening, cancer testing, and smoking cessation.

Staff were trained in how to help patients who did not have a permanent address in the area, whether as temporary residents, migrant workers or the homeless and traveller populations. They were clear on the processes in place for the patient to register as a temporary patient.

Summary of findings

Practice staff were able to refer patients with alcohol or drug addictions to an alcohol/drug service for support and treatment. One GP had a particular interest in this field and held a monthly clinic for these patients. The practice also held a weekly clinic with a drug and alcohol misuse counsellor.

Patients with learning disabilities were offered and provided a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate.

There was a health trainer based at the practice who worked with vulnerable patients providing healthy eating advice, encouraging exercise and also organised group activities such as walking and swimming clubs. They also organised cooking lessons for patients with learning disabilities.

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). Care was tailored to patients' individual needs and circumstances, including their physical health needs. Annual health checks were offered to people with serious mental illnesses. GPs had the necessary skills and information to treat or refer patients with poor mental health. The practice had recently undertaken an audit of their patients to identify anyone who may have dementia. They cross checked patient's coding against medicines and diagnosis. They identified another nine patients who were then entered onto the dementia register and they were then able to receive extra support and care where needed.

The practice employed a carer support worker one day a week who is pivotal in supporting carers and particularly where patients were affected by dementia. We saw evidence that showed patients valued this service and saw the practice were proactive in keeping updated with the latest information and advice available.

Summary of findings

What people who use the service say

We spoke with six patients during our inspection. The practice has an active patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected 25 comment cards all of which contained detailed positive comments.

Comment cards stated that patients were grateful for the caring attitude of the staff and for the staff who took time to listen effectively. Comments also highlighted patients' confidence in the advice and medical knowledge, access to appointments and praise for the continuity of care and not being rushed.

These findings were reflected during our conversations with patients. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and they received good treatment. Patients told us that the GPs were excellent.

They told us they were happy with the appointment system and everyone we spoke with told us access to GPs was good, with same-day appointments being available. They all told us they spoke to a medical professional on the same day they made contact with the practice, and appointments were made if required. They told us there was no difficulty getting through to the practice by telephone. Patients told us they were able to request to see a GP of their choice and they felt their requests were met whenever possible. They also told us they could request an appointment with a GP of a specific gender.

Port View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor and a practice manager specialist advisor.

Background to Port View Surgery

The practice provides primary medical services to people living in the town of Saltash, Cornwall and the surrounding areas. At the time of our inspection there were approximately 6580 patients. The practice provides services to a diverse population age group and is situated in a town centre location.

The practice comprises of a team of five GP partners (three male and two female) who hold managerial and financial responsibility for running the business. In addition there is a salaried GP, four registered nurses and two health care assistants. An administration team and a full time practice manager are employed in the running of the practice.

Port View is open between Monday and Friday from 8.30am-6pm with extended opening hours offered two mornings and two evenings a week and Saturday mornings once a month. Outside of these hours a service is provided by another health care provider, which patients' access by dialling a national service number.

The practice has an established patient participation group (PPG). This is a group that acts as a voice for patients at the practice.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme. This provider had not been inspected before and that was why we included them.

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

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

How we carried out this inspection

The inspection team carried out an announced inspection of Port View Medical Practice on 13 January 2015. We spoke with six patients and 11 members of staff. We spoke with three members of the patient participation group (PPG). The purpose of a PPG is to comment on the overall quality of the service at the practice and to act as an advocate on behalf of patients when they wish to raise issues.

Detailed findings

We observed how reception staff dealt with patients in person and over the telephone. We discussed patient care plans. We spoke with and interviewed a range of staff including GPs, the practice manager, the practice nurses, reception and administrative staff. We also reviewed comment cards where patients shared their views and experiences of the service. These had been provided by the Care Quality Commission (CQC) before our inspection took place. In advance of our inspection we talked to the local clinical commissioning group (CCG) and the NHS England local area team about the practice.

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)

Good

Are services safe?

Our findings

Safe track record

We saw evidence that the practice had a good track record for maintaining patient safety. Information from the quality and outcomes framework (QOF), which is a national performance measurement tool, showed that significant events were appropriately identified and reported. GPs told us they completed incident reports and carried out significant event analysis as part of their on-going professional development. For example, we saw a report which showed how a vulnerable patient who lived at home had not been taking their medicine as regularly as they should have. This was reported to the practice by a member of the rapid response team. No previous concerns had been identified but upon investigation it was found f that no requests for a repeat prescription had been asked for by the patient. As a result of this a complete audit was undertaken of all patients with hypothyroid and diabetes who had not requested medicine in the past six months. This event was discussed with Community Matron and all GPs for guidance. One issue identified was the lack of computer record when visiting patients at home. The practice was investigating the costs of purchasing a hand held devices to take on visits.

The management team, GPs and practice nurses discussed significant events at their regular meetings. These were also discussed by staff and other external staff that attended the meetings so that the provider as a whole learnt from incidents, shared ideas for improvement and took action to reduce the risk of the event re-occurring. The meeting minutes we reviewed provided evidence of new guidelines, complaints, and incidents being discussed positively and openly. All the staff we spoke with, including reception staff, were aware of the significant event policy and knew how to escalate any incidents. They were aware of the forms they were required to complete and knew who to report any incidents to at the practice.

Learning and improvement from safety incidents

The process following a significant event or complaint was formalised and followed a set procedure. GPs discussed the incidents as they occurred but more formally at bi-monthly clinical meetings where actions and learning outcomes were shared with all staff. We were given eight clear examples of where practice and staff action had been prompted to change as a result of incidents. These included changes in protocols, additional training for staff and further communication for all staff. There were systems to record any incidents occurring (or 'near misses') so that lessons could be learnt and procedures changed if necessary to reduce the risks in future. There were systems in place to make sure any medicines alerts or recalls were actioned by staff.

Reliable safety systems and processes including safeguarding

The practice had an up to date safeguarding children, young people, and vulnerable adults policy in place. This provided staff with information about safeguarding legislation and how to identify report and deal with suspected abuse. One of the GPs took the lead for safeguarding, and all the staff we spoke with were aware of who the lead was and how they could access the policy on their computers. Staff also had access to the contact details of child protection and adult safeguarding teams in the area.

Clinical staff had received safeguarding training up to level three, and non-clinical staff up to level two. Level three is the highest level of safeguarding training and met best practice. We saw that the training for all staff was up to date. All the staff we spoke with were able to discuss what constituted a child and adult safeguarding concern. They were aware of how to report suspected abuse and who to contact if they needed advice. We were given examples of safeguarding concerns being raised with the relevant authorities and how the practice had been involved in managing these concerns. The safeguarding lead attended local case conferences and completed necessary reports. Non-clinical staff were aware of their responsibilities and said they would feel confident raising concerns.

Medicines management

The GPs were responsible for prescribing medicines at the practice and there were several dispensing pharmacies nearby. We looked at all the areas in the practice where medicines were stored. Emergency medicines for cardiac arrest, anaphylaxis and low blood sugar were available within each clinic and treatment room. We checked the emergency drug boxes and saw that medicines were stored appropriately and were in date. Vaccines were stored appropriately and there were auditing systems in place to ensure that the cold chain was maintained, so these

products would be safe and effective to use. We found that medicines kept in GP bags were the responsibility of each GP to maintain supplies and ensure expiry dates were checked. There were policies explaining the practice nurses would monitor this. We saw that there were detailed policies and standard operating procedures in place to guide staff on the safe management and handling of medicines, and that these were regularly updated. Controlled drugs were kept securely locked in a cabinet. These were audited and checked appropriately.

The practice had a protocol for repeat prescribing which was in line with national guidelines. This covered how staff that generate prescriptions were trained and how changes to patients' repeat medicines were managed. Patients were satisfied with the repeat prescription processes. They were notified of health checks needed before medicines were issued. Patients explained they could use the box in the surgery, send an e-mail, or use the on-line request facility for repeat prescriptions.

Cleanliness and infection control

During our inspection we looked at all areas of the practice, including the GP surgeries, nurse's treatment rooms, and patient's toilets and waiting areas. All appeared visibly clean and were uncluttered. The patients we spoke with commented that the practice was clean and appeared hygienic. Cleaners were employed by the practice and there was a cleaning schedule in place to make sure each area was thoroughly cleaned on a regular basis. There was also a record that each task had been carried out. The practice was cleaned in line with infection control guidelines, with the cleaners routinely attending every evening.

There was an infection control policy in place .This gave full information about aspects of infection control such as the handling of specimens, hand washing, and the action to be taken following exposure to blood or bodily fluids. The lead nurse was the lead for infection control in the practice. Infection control training was provided for all staff as part of their induction, and we saw evidence that the training was updated annually. The staff we spoke with confirmed they had received training and said any updated guidance relating to the prevention and control of infection was communicated to them by the infection control lead.

We saw there were hand washing facilities in each surgery and treatment room and instructions about hand hygiene were displayed. Hand wash and paper towels were next to each hand wash basin, and hand gel was available throughout the practice. Protective equipment such as gloves, aprons and masks were readily available. Curtains around examination couches were disposable and had been replaced within the past six months. Examination couches were washable and were all in good condition. An infection control audit had been carried out in December 2014 whereby some issues were identified as needing improvement. We saw evidence that these had since been undertaken. For example the de cluttering of some areas. Another audit was planned in six months.

Equipment

Emergency equipment available to the practice was within the expiry dates. The practice had a system using checklists to monitor the dates of emergency medicines and equipment which helped to ensure they were discarded and replaced as required. Equipment such as the weighing scales, blood pressure monitors and other medical equipment were serviced and calibrated where required.

Portable appliance testing (PAT), where electrical appliances were routinely checked for safety annually, was last carried out in December 2014. Staff told us they had sufficient equipment at the practice.

Staffing and recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. The practice said they used locums as staff cover but tried to use the same one for continuity. GPs told us they also covered for each other during shorter staff absences.

The practice used a team approach where the workload for part time staff was shared equally. Staff explained this worked well but there remained a general team work approach where all staff helped one another when one particular member of staff was busy.

Recruitment procedures were in place and staff employed at the practice had undergone the appropriate checks prior to commencing employment. Once in post staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

Criminal records checks were performed for GPs and nursing staff. Administrative staff are checked if required based on an initial risk assessment.

Good

Are services safe?

The practice had clear disciplinary procedures to follow should the need arise.

The registered nurses Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were listed on the professional register, to enable them to legally practice as a registered nurse.

Monitoring safety and responding to risk

The practice had a suitable business continuity plan that documented their response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment.

Nursing staff received any medical alert warnings or notifications about safety by email or verbally from the GPs or practice manager. There was a system in operation to ensure one of the nominated GPs covered for their colleagues, for example home visits, telephone consultations and checking blood test results.

Arrangements to deal with emergencies and major incidents

Appropriate equipment was available to deal with an emergency, for example if a patient should collapse. The staff we spoke with all knew where to easily locate the equipment and emergency medicines. The emergency equipment was well maintained and effective checks were in place to ensure emergency medicine and equipment did not expire. All staff, including administration staff had received training in emergency procedures.

Emergency medicines for cardiac arrest, anaphylaxis and hypoglycaemia were available and all staff knew their location.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients spoken with said they received care appropriate to their needs. They told us they were included as much as possible and were helped to come to decisions about the treatment they required. New patient health checks were carried out by the practice nurses and cardiovascular and other regular health checks and screenings were on going in line with national expectations.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, eye disease, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach. Care plans had been put in place for two percent of the practice patients who met the criteria to avoid unplanned admissions to hospital. This was part of national enhanced services and GPs had initiated the plans with patients in their own home and included their family and/or carers where appropriate. Multi-disciplinary meetings were held regularly to discuss individual cases making sure that all treatment options were covered. The clinicians aimed to follow best practice such as the National Institute for Health and Care Excellence (NICE) guidelines when making clinical decisions.

Management, monitoring and improving outcomes for people

Information about the outcomes of patients care and treatment was collected and recorded electronically in individual patient records. This included information about their assessment, diagnosis, treatment and referral to other services.

The practice had a system in place for completing clinical audit cycles. These are quality improvement processes that seek to improve patient care and outcomes through the systematic review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to, hospital admissions in patients over 75 years of age and medicine. We saw that where audits identified actions these were clearly described.

We saw evidence of peer review and support and regular clinical and practice meetings being held to monitor and identify possible issues and improvements in respect of clinical care.

The GPs, nurse practitioner, practice nurses and administration staff had developed areas of expertise and provided advice and support to colleagues in respect of their individual area. There was a truly holistic approach to assessing, planning and delivering care and treatment to patients.

Effective staffing

All of the GPs in the practice participated in the appraisal system leading to revalidation over a five-year cycle. The GPs we spoke with told us these appraisals have been appropriately completed. Nursing and administration staff received an annual formal appraisal and kept up to date with their continuous professional development programme.

There were effective staffing and recruitment policies to ensure staff were recruited and supported appropriately. Paper and computer staff records demonstrated that staff had been recruited and employed in line with the practice policy. Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development.

Staff said they all received an annual appraisal and attended regular staff meetings to enable information sharing. Nursing staff received clinical supervision from the GP partners. They also met with the GPs informally to discuss clinical issues and diagnoses. All staff told us they had access to training related to their roles. Staff were alerted by the practice manager to concerns about faulty equipment from MHRA alerts. Patients were treated effectively by informed staff.

All the staff we spoke with said they felt well supported by the GPs and nursing team as well as by the practice manager and each other. Patients told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with colleagues and other services

We found that the practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X-ray results, letters from hospital A and E and outpatients and discharge summaries, out of hours providers and the 111 service were received electronically or by post. These are seen and actioned by a GP on the day they are received. Outpatient letters are reviewed in less than five days from receipt. The GP seeing

Good

Are services effective?

(for example, treatment is effective)

documents and results was responsible for the action required. They either recorded the action or arranged for the patient to be contacted and seen as clinically necessary. We saw that this process worked well.

Once a month there was a meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as social workers, palliative care team, physiotherapists, occupational therapists, community matrons and the mental health team.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local out of hour's provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals. Staff reported that this system was easy to use. Regular meetings were held throughout the practice.

Information about risks and significant events were shared openly at meetings and all staff were able to contribute to discussions about how improvements could be made. The management team attended Clinical Commissioning Group (CCG) meetings and information from these meetings was fed back to staff.

There was a practice website with information for patients including signposting, services available and latest news. Patients registered so they could access the full range of information on the website. Information leaflets and posters about local services were available in the waiting area. The practice also had a social media account and this was used to provide timely updates to patients.

Consent to care and treatment

We saw examples of how young people, those with learning disability, those with mental health problems and those with dementia were supported to make decisions. The staff demonstrated a clear understanding of the Gillick competencies used to make decisions about patients under 16 years old giving their consent.

The nurse told us that she explained treatments and tests to patients before carrying out any procedures. Patients were given an explanation of what was going to happen at each step so that they knew what to expect.

Patients told us they felt that they had been involved in decisions about their own treatment and that the GP gave them plenty of time to ask questions. They were satisfied with the level of information they had been given and said that any next steps in their treatment plan had been explained to them.

We saw the practice's consent policy and its guide to the Mental Capacity Act 2005 (MCA). These provided staff with information about making decisions in the best interest of patients who lacked the capacity to make their own decisions. GPs and nurses were aware of patients who needed support from nominated carers and ensured that carers' views were listened to as appropriate. Best interest meetings were held when a patient lacked capacity to make the decisions regarding their care themselves.

Health promotion and prevention

Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people was perceived as an opportunity to do so.

New patients, including children, were offered appointments to establish their medical history and current health status. This enabled the practice to identify who required extra support such as patients at risk of developing, or who already had, an existing long term condition such as diabetes, high blood pressure or asthma.

A wide range of health promotion information was available and accessible to patients particularly in the reception and waiting areas and on the practice website. This was supplemented by advice and support from the clinical team at the practice at each consultation. Health promotion services provided by the practice included smoking cessation services and a weight management. The practice had arrangements in place to provide and monitor an immunisation and vaccination service to patients. For example we saw that childhood immunisation, influenza, travel and other relevant vaccinations were provided.

A system was in place to provide health assessments and regular health checks for patients when abnormalities or long term health conditions are identified. This included sending appointments for patients to attend reviews on a regular basis. When patients did not attend this was followed up to determine the reason and provide an alternative appointment.

Good

Are services effective?

(for example, treatment is effective)

Patients were provided with fitness to work advice to aid their recovery and help them return to work.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We received 25 completed CQC comment cards, spoke with six patients on the day of inspection and two members of the practice's patient participation group (PPG). We spoke with people from various age groups and with people who had different health care needs.

Patients we spoke with and who completed our comment cards were complimentary about the way they were treated by the doctors and nurses and other members of the practice team. They told us they were treated with respect and their privacy and dignity were maintained.

There was a strong, visible, patient-centred culture. Staff were motivated and inspired to offer care that was kind and promotes people's dignity. Relationships between patients, those close to them, and staff were strong, caring and supportive. These relationships were highly valued by all staff and promoted by the practice management team. Staff were seen to be respectful, pleasant and helpful with patients and each other during our inspection visit.

Patients informed us that their privacy and dignity was always respected and maintained particularly during physical or intimate examinations. All patient appointments were conducted in the privacy of individual consultation room. Examination couches were provided with privacy curtains for use during physical examination and a chaperone service was provided.

Care planning and involvement in decisions about care and treatment

The patients we spoke with told us they felt fully involved in decisions about their care and treatment and the GPs and nurses explained all aspects of their care to them in a way they understood. They told us they felt listened to and were able to freely express their opinions during consultations. We saw that care plans were in place for some patients with a view to avoiding unnecessary hospital admissions. In addition all patients with long term conditions such as chronic obstructive pulmonary disease (COPD) or asthma were invited to attend an annual review of their condition.

Patient/carer support to cope emotionally with care and treatment

There was a patient centred culture where the practice team worked in partnership with patients and their families. This included consideration of the emotional and social impact a patients care and treatment may have on them and those close to them. The practice had taken proactive action to identify, involve and support patient's carers. This included providing information at the practice (and on their website) to encourage carers to identify themselves and engage with the practice to access support.

A wide range of information about how to access support groups and self-help organisations was available and accessible to patients from the practice clinicians, in the reception area and on the practice website.

A counselling support service was also available to provide emotional support to patients following referral by the GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the service was responsive to people's needs and had sustainable systems in place to maintain the level of service provided. The practice held information about the prevalence of specific diseases. This information was reflected in the services provided, for example screening programmes, vaccination programmes and reviews for patients with long term conditions.

The practice was proactive in contacting patients who failed to attend vaccination and screening programmes. They were currently trialling different ways of inviting patients for an NHS health check. Early indications were that notifying certain groups of patients by text message had a more positive effect than writing to them. Appointment reminders by text message also decreased the number of patients who did not attend their appointments. If patients did not attend an appointment they received a telephone call to see if everything was okay. Where a patient was housebound or could not attend the practice due to their condition a home visit was arranged.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice team had taken into account the differing needs of people by planning and providing care and treatment services that were individualised and responsive to individual needs and circumstances. This included having systems in place to ensure patients with complex needs were enabled to access appropriate care and treatment such as patients with a learning disability or dementia. People in vulnerable circumstances were able to access care and treatment with the practice, including those that were homeless.

Access to the service

The appointments system was easy to use and supported patients to make appointments. Waiting times, delays and cancellations were minimal and managed appropriately. People were kept informed of any disruption to their care or treatment. Patients commented positively in respect of being able to access the service. We also looked the results of the 2014 GP survey. 60% of the respondents found it easy or fairly easy to make an appointment but found it sometimes difficult to get through by phone early in the morning. 81% of patients who responded said they were satisfied with their overall experience at the practice.

The opening hours and surgery times at the practice were prominently displayed in the reception area, the patient practice information booklet and on the practice website. To improve patient access the practice offered extended opening hours from 7.30am until 7.30pm twice a week and a Saturday morning surgery once a month. These hours of access were particularly helpful to patients who worked office hours. Routine appointments and same day appointments were provided. Routine appointments could be booked up to two weeks ahead. GP consultations were provided in 15 minute appointments. Where a patient required longer appointments these could be booked by prior arrangement. There were also arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, there was an answerphone message giving the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients at the practice and on the practice website.

There was level access via the front entrance of the practice and access up steep stairs from the car park at the rear of the practice. The practice also used a hearing loop system for those patients who were hard of hearing.

Listening and learning from concerns and complaints

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

There was no complaints process publicised in the waiting room, however this was rectified on the day of our inspection and a procedure displayed. The complaints procedure was on the practice website and in the practice leaflet. Patients we spoke with had not had any cause to complain but they believed any complaint they made would be taken seriously.

We saw the practice's log and annual review of complaints received. The review recorded the outcome of each complaint and identified where learning from the event had been shared at a practice meeting.

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 promote good outcomes for patients. It actively promoted a learning culture. We saw the business plan that was in place, and saw the practice's vision and values were included in various documents. We spoke with 11 members of staff they were all aware of the vision and values of the practice and knew what their responsibilities were in relation to these. We saw that the regular staff meetings helped to ensure the vision and values were being upheld within the practice.

Governance arrangements

All staff understood their role and responsibilities and demonstrated appropriate accountability in the way they supported and treated patients in their care. There were clear lines of accountability with regard to making specific decisions, especially decisions about the provision, safety and adequacy of the care provided and these were aligned to risk.

Policies and procedures underpinning adult and children safeguarding at the practice were kept under review by this GP and referenced national guidance and current local safeguarding processes. Administrative staff held specific responsibilities for example with regard to alerts from the Medicines and Healthcare products Regulatory Agency (MHRA). These were escalated to the GP prescribing lead and were then discussed with the pharmacist who helped in raising awareness across the clinical team about potential risks and necessary actions to take.

Practice nurses told us they were supported through the local practice nurse forum and links with the modern matron and other specialist nurses. Training needs were identified and support given to staff to undertake additional training to increase their skill base.

There were management systems in place to monitor the quality of the service provided. Regular reports were provided to the Clinical Commissioning Group (CCG). This included performance information, clinical and strategic management.

The practice had a system in place for completing clinical audit cycles. These were improvement processes that sought to improve patient care and outcomes through the review of patient care and the implementation of change. We saw examples of these at the practice including audits relating to hospital admissions in patients over 75 years of age and medicine. We saw that where audits identified actions these were clearly described.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example one of the practice nurses led on infection prevention and one of the GPs led on safeguarding. There were high levels of staff satisfaction. Staff were proud of the practice as a place to work and spoke highly of the quality of the leadership, culture and support provided. There were consistently high levels of constructive staff engagement.

Discussion with staff and records we saw demonstrated clinical and staff meetings were held regularly. Staff told us that they had the opportunity and were comfortable to raise issues at staff meetings, at individual appraisal meetings or any other time if necessary.

Human resources policies and procedures were in place to support staff. We saw these were available to all staff electronically. Polices regarding equality and bullying and harassment at work were included. Staff told us they were aware of the policies and how to access them. All staff had an annual review of their performance during an appraisal meeting. This gave staff an opportunity to discuss their objectives, any improvements that could be made and training that they needed or wanted to undertake. Clinicians also received appraisal through the revalidation process. Revalidation is where licensed doctors are required to demonstrate that they are up to date and fit to practice.

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

Patient feedback was valued by the practice. This was demonstrated by a recent change in the telephone call system. The practice had a patient participation group (PPG). The PPG representatives who came to the inspection said the practice manager and GP representative were keen to encourage patient feedback and involvement. The PPG said they were regularly consulted about various issues and had been able to influence this decision and suggest additional ideas. The PPG was advertised on the practice website along with information on how patients could offer feedback.

Are services well-led?

Good

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

Management lead through learning and improvement

A standardised, formal, systematic process was followed to ensure that learning and improvement took place when events occurred or new information was provided. For example, the practice had a calendar of meeting dates to discuss current issues. There was formal protected time set aside for continuous professional development for staff and access to further education and training as needed.

The practice had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. There were environmental assessments for the building. For example, annual fire assessments, electrical equipment checks, control of substances hazardous to health (COSHH) assessments and visual checks of the building had been maintained.