Park View Surgery

Quality Report

23 Ribblesdale Place
Preston
Lancashire
PR1 3NA
Tel: 01772 258474
Website: www.parkviewpreston.co.uk

Date of inspection visit: 08/04/2015
Date of publication: 21/05/2015

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 Park View Surgery on 08 April 2015. We had previously inspected this practice in July 2014 and had identified some areas where they were not meeting the Health and Social care Act 2008 (Regulated Activities) Regulations 2010. We followed up on the action plan the practice had submitted to address the issues highlighted.

Overall the practice is rated as good. We found the practice to be good for providing safe, well-led, effective, caring and responsive services.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- 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 told us they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We also saw areas of outstanding practice:

Summary of findings

- Although all staff recognised their responsibilities with regard to safeguarding. We were given specific details of where non clinical staff had been vigilant and acted outside of the usual expectation of this group of staff. They had alerted clinical staff to potential risk and this risk had been subsequently acted upon.
- The practice had been successful in securing funding to pilot a scheme whereby they had a Community Psychiatric Nurse (CPN) on their staff to promptly assist patients within the practice with their mental health crisis needs. The CPN was seeing patients that would otherwise have had to be referred on to local Mental Health Trust. Whose current waiting time for counselling was 11 weeks, Cognitive Behavioural Therapy was 13-17 weeks and for appointments with the Psychological wellbeing practitioners in Preston was 15-22 weeks. The CPN would see patients within a week and offer assistance and support.

In addition the provider should:

- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Should ensure they follow their policy on complaints and send patients a holding letter once they receive a complaint into the practice.
- Formally record and make available minutes of non-clinical staff meeting to all staff.
- Ensure if administration staff are to be used as chaperones they have adequate training.
- Ensure when carrying out minor surgery the GPs follow the practice policy and record written consent on the available forms and scan onto patients' records and not just record in the minor operations log book.

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, report incidents and near misses. Lessons were learned and communicated widely to support improvement.

Staff were knowledgeable about what constituted a safeguarding concern. GPs and the nurse practitioner took the position of safeguarding leads for the practice and staff knew who to contact.

Recruitment checks highlighted as not being followed in a previous inspection were conducted for all staff.

Risk management and information relating to safety was monitored, reviewed and addressed. There was sufficient staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Care and treatment was delivered in line with current published best practice. Staff meetings and audits were used to assess how well the service was delivered.

Consent to treatment was always obtained where required and this was confirmed when speaking with patients. However consent for minor surgery did not fully follow the surgery policy.

Clinical Commissioning Group (CCG) data showed patient outcomes were in line with the average for the locality. National Institute of Health and Care Excellence (NICE) guidance was referenced routinely.

Staff had received training appropriate to their roles. The practice undertook appraisals for staff and we were shown an on going programme for this.

The practice regularly met with other health professionals and commissioners in the local area in order to review areas for improvement and share good practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Results from patient surveys showed patients rated the practice high for several aspects of care. Patients said they were treated with compassion, dignity and respect. They were involved in planning for their care and treatment. We observed a patient centred culture and found strong evidence staff were motivated and inspired to offer kind and compassionate care.

Summary of findings

Staff were familiar with patients and recognised when patients needed extra support or assistance and strived to ensure this need was met.

Are services responsive to people's needs?

Good

The practice is rated good for providing responsive services.

The practice reviewed the needs of their local population and engaged with the NHS England Local Area Team (LAT) and the Clinical Commissioning Group (CCG) to secure service improvements where possible.

Patients reported good access to the practice. Appointments were available the same day.

The practice sought to gain patient feedback and had an active virtual Patient Participation Group (PPG) who provided ideas and suggestions to help improve the service.

We saw evidence that complaints were responded to quickly and that staff were involved in discussions around ways to improve. The practice reviewed complaints on an annual basis to identify any recurrent trends.

Are services well-led?

Good

The practice is rated as good for providing well-led services. The practice had a clear vision which had quality patient care as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

Governance and performance management arrangements were proactively reviewed. We found there was a high level of staff engagement with an open door policy for access to all senior staff. Staff told us they were very satisfied with their roles. The practice sought feedback from patients and acted upon it where possible.

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 20.8% of the patient population were aged 65 or over which was in line with the national average. The practice had good outcomes for conditions commonly found amongst older people. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, avoidance of unplanned admissions to hospital, timely diagnosis and support for people with dementia, and a shingles vaccination programme for those aged 70 and above. The practice was responsive to the needs of older people including offering home visits.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There was a high prevalence (48.9%) of patients with long standing conditions, such as cardiovascular disease and Chronic Obstructive Pulmonary Disease (COPD) amongst the patient population. Nursing staff had received appropriate training which enabled them to focus upon specific chronic conditions and appropriately assist in the management of them through a comprehensive schedule of clinics. These patients were recalled annually which ensured they had structured annual reviews to check their health and medication needs were being met.

GPs worked with relevant health and care professionals to deliver a multidisciplinary package of care for those patients with the most complex needs. The practice offered enhanced services to meet the needs of patients with long-term conditions such as avoidance of unplanned admissions to hospital through care planning.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. Systems were in place for identifying and following up children who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation clinics for babies and young children were available on a weekly basis. A range of enhanced services were available such as whooping cough in pregnant women, hepatitis B for new born babies, Measles Mumps and Rubella (MMR) vaccination for young people. Contraception services were available within the practice. Appointments both routine and urgent were available outside school hours and the premises were suitable for children and babies. Children and young people were treated in an age

appropriate way and recognised as individuals. The population group of under 18 year olds accounted for 34.2% of the practice patient population which is slightly higher than both the Clinical Commissioning Group (CCG) and national average for this age group.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible. Patients were able to book appointments and request repeat prescriptions using online facilities and there were extended opening hours for appointments including Saturday morning clinics. A full range of health promotion and screening services were available which reflects the needs for this age group was available within the practice. This age group was the largest group within the practice at 45% which was one of the highest in the Clinical Commissioning Group. (CCG)

People whose circumstances may make them vulnerable

Good

The practice is rated good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances for example those with learning disabilities. Patients with learning disabilities were offered annual health checks and longer appointments were available if required. The practice effectively supported carers who were sometimes vulnerable themselves alongside the person they were caring for.

The practice supported patients living in residential facilities for people with alcohol and drug dependency problems. There was also a woman's refuge and homeless shelter who registered temporary patients with the practice. The practice actively sought to include these vulnerable patients in the ongoing management of their care by a variety of means including offering appointments at short notice. The practice facilitated Help Direct to hold weekly clinics on their premises to assist patients with their housing, financial and social health needs.

One GP worked with the drug worker for substance misuse patients, seeing them at the surgery. This was beneficial to the patients as they were not attending the local clinics where they may be exposed to the substances they were trying to avoid.

The practice worked with multidisciplinary teams in the case management of vulnerable patients. Staff knew how to recognise the signs of abuse in vulnerable adults and children. Staff were

aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. We were shown evidence to demonstrate where the vigilance of administration staff had instigated activity to ensure the protection of vulnerable patients within the practice on a number of occasions.

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). Patients within this group received a timely recall for their annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service available.

The practice provided an enhanced service with a view to facilitating timely diagnosis and support for people with dementia which they were actively working to improve upon. This ensured timely assessment by the GP using a recognised cognitive process which could be carried out for patients identified as at risk of dementia. Staff told us they actively sought out patients with 'hidden dementia'. This was done by discussion with patients at routine appointments. They had a process in place if a member of staff felt a patient had declined or needed further investigation they could raise this with one of the GPs who would arrange an appointment

Staff told us the practice had sign-posted patients experiencing poor mental health to various support groups, and they were proactive in helping patients address issues to improve all aspects of their health. The practice had successfully begun a pilot for the Clinical Commissioning Group. (CCG) area by having a Community Psychiatric nurse employed within the practice. This assisted patients in crisis and it was hoped that this support would reduce the need for this group of patients to attend A&E for support.

Summary of findings

What people who use the service say

We received seven completed Care Quality Commission (CQC) comment cards which included feedback from male and female patients across a broad age range and spoke with four patients during the inspection. Patients spoke positively about the practice, and the care and treatment they received. All patients commented on the practice environment. They told us it was always safe and hygienic. Their descriptions of staff included helpful, friendly, thorough and kind. Patients told us staff understood and they were treated with dignity, compassion and respect. They told us staff listened to them and took time to discuss and explain treatment options.

Patients felt involved in planning their care and treatment. Patients told us urgent appointments were always available. They told us on the whole they did not struggle to get appointments.

We spoke with a member of the Patient Participation Group (PPG) who was very positive about the practice. They told us they felt fully involved in the practice and felt their views were listened to and acted upon when appropriate.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is an auditable system for reviewing and monitoring the recording of serial numbers on blank hand written prescriptions pads held in storage and once allocated to GPs.
- Should ensure they follow their policy on complaints and send patients a holding letter once they receive a complaint into the practice.
- Formally record and make available minutes of staff meeting to all staff.
- Ensure if administration staff are to be used as chaperones they have adequate training..
- Ensure when carrying out minor surgery the GPs follow the practice policy and record written consent on the available forms and scan onto patients' records and not just record in the minor operations log book.

Outstanding practice

- Although all staff recognised their responsibilities with regard to safeguarding. We were given specific details of where non clinical staff had been vigilant and acted outside of the usual expectation of this group of staff. They had alerted clinical staff to potential risk and this risk had been subsequently acted upon.
- The practice had been successful in securing funding to pilot a scheme whereby they had a Community Psychiatric Nurse (CPN) on their staff to promptly assist patients within the practice with their mental health crisis needs. The CPN was seeing patients that would otherwise have had to be referred on to local Mental Health Trust. Whose current waiting time for counselling was 11 weeks, Cognitive Behavioural Therapy was 13-17 weeks and for appointments with the Psychological wellbeing practitioners in Preston was 15-22 weeks. The CPN would see patients within a week and offer assistance and support.

Park View Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

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

Background to Park View Surgery

Park View Surgery is situated close to the city centre of Preston in a residential area. There are currently 5500 patients registered with the practice. The practice held a Personal Medical Services contract with the local Clinical Commissioning Group to provide Primary Medical Care to patents in the area.

The patient population groups are in line with the Clinical Commissioning Group (CCG) and National averages except for the age group 18-65 years which is higher than both local and national averages. This practice has a minimal annual turnover of patients. Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice team comprises of three GPs including one female, two nurses with a variety of skills and qualifications including nurse prescribing and two health care assistant working a variety of hours. The practice manager is supported by a team of reception and administrative staff. The practice has an active virtual patient participation group.

Opening hours are 8am-6pm Monday to Wednesday and Friday, 8am-1pm Thursday, Extended surgery hours are available on Monday from 6pm -8pm and 9am to 12midday on Saturday where there are two surgeries available. Surgeries are available mornings, afternoons and evenings. When the practice is closed an out of hours service, Preston Primary Care Centre, meets the care and treatment needs of patients.

The practice is a training practice for doctors who wish to gain experience as GPs, with two doctors currently in training. The practice had recently secured placements for Student Nurses from the local university to gain Primary Health Care experience within the surgery.

The practice informed us their estimate for patients from diverse ethnic population groups registered with the practice was approximately 66% of their practice population.

Why we carried out this inspection

Park View Surgery is situated close to the city centre of Preston in a residential area. There are currently 5500 patients registered with the practice. The practice held a

The patient population groups are in line with the Clinical Commissioning Group (CCG) and National averages except for the age group 18-65 years which is higher than both local and national averages. This practice has a minimal annual turnover of patients. Information published by Public Health England rates the level of deprivation within the practice population group as two on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

The practice team comprises of three GPs including one female, two nurses with a variety of skills and qualifications including nurse prescribing and two health care assistant

working a variety of hours. The practice manager is supported by a team of reception and administrative staff. The practice has an active virtual patient participation group.

Opening hours are 8am-6pm Monday to Wednesday and Friday, 8am-1pm Thursday, Extended surgery hours are available on Monday from 6pm -7.30pm and 9am to 1pm on Saturday mornings where there are two surgeries available. Surgeries are available mornings, afternoons and evenings. When the practice is closed an out of hours service, Preston Primary Care Centre, meets the care and treatment needs of patients.

The practice is a training practice for doctors who wish to gain experience as GPs, with two doctors currently in training. The practice had recently secured placements for Student Nurses from the local university to gain Primary Health Care experience within the surgery.

The practice informed us their estimate for patients from diverse ethnic population groups registered with the practice was approximately 66% of their practice population.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice, together with information the practice had submitted in response to our previous inspection. We also asked other organisations to share what they knew. We spoke with a member of the practice Patient Participation Group. The information reviewed did not highlight any risks across the five domain areas.

We carried out an announced visit on 8th April 2015. During our visit we spoke with GPs, members of the nursing team, the practice manager, patients, reception and administrative staff. We observed how people were communicated with. We reviewed CQC comment cards where patients and members of the public were invited to share their views and experiences of the service. The CQC comment cards were made available at the surgery prior to inspection.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. Including investigating reported incidents, checking national patient safety alerts and sharing 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. Reports and data from NHS England indicated that the practice had a good track record for maintaining patient safety.

We reviewed safety records and incident reports. The practice manager, clinicians and any other relevant staff investigated and reported on the incidents and events. Documented evidence confirmed that incidents were appropriately reported. Staff we spoke with all said that there was an open and 'no blame' culture at the practice that encouraged them to report adverse events and incidents.

Minutes of clinical and multi-disciplinary team meetings provided clear evidence that incidents, events and complaints were discussed and where appropriate actions and protocols were identified to minimise re-occurrence of the incident or complaint. Records were available that showed the practice had consistently reviewed and responded to significant events, incidents and complaints and so could show evidence of a safe track record over the long term. However minutes of non-clinical staff meetings were recorded in the practice managers note book and not formally distributed to staff. As such staff had no record of any discussion that had taken place and there was no follow up of actions identified at the next meeting.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the previous 12 months. Significant events were a standing item on the practice clinical meeting agenda. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. All staff we spoke with, including receptionists, administration and nursing staff, knew how to raise an issue at the meetings and they felt encouraged to do so.

We saw evidence to confirm that, as individuals and as a team, staff were actively reflecting on their practice and critically looked at what they did to see if any improvements could be made. GPs told us they completed incident reports and carried out significant event analysis routinely and as part of their ongoing professional development. We looked at some recent significant events from 2014 and 2015 which had been analysed, reported and discussed with relevant staff. Where required changes to protocols and processes were implemented. One significant event was discussed with the team regarding a prescription being given to the wrong patient with a similar name. This had resulted in a change of process and patients were now asked to confirm their name, address and date of birth before issuing the prescriptions.

National patient safety alerts were disseminated by the practice manager to relevant staff. Staff we spoke with were able to give an example of recent alerts/guidance 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. We asked members of medical, nursing and administrative staff about their understanding of abuse and their responsibilities when they suspected a patient was at risk of abuse. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. One non clinical staff member provided us with a recent example where they had highlighted during their routine work a potential risk to a child and had brought this to the attention of the GP and further action was pursued to maintain the safety of the child.

All staff had access to the practice policy and procedure for safeguarding children and adults. They knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours.

All the GPs and the nurse practitioner acted as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training 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 other staff were trained to a level appropriate to their role.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. One non clinical staff member discussed with us an incident where a child had not attended for their appointment and they had a flag on their records for safeguarding so they had highlighted this to the GP. The GP subsequently rang the family and discussed the non-attendance with the parent.

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 support and a safeguard and witness for a patient and health care professional during a medical examination or procedure). The nursing staff, the health care assistants acted as chaperone where available. The practice should note if they wish to use their administration team as chaperones they must offer appropriate training in the role beforehand.

Medicines management

We checked medicines stored in the treatment rooms and fridges. We found that they were stored appropriately. There was a current policy and procedures in place for medicines management including cold storage of vaccinations and other drugs requiring this. We saw the checklist that was completed daily to ensure the fridge remained at a safe temperature and staff could tell us of the procedure in place for action to take in the event of a potential failure of the cold chain. A cold chain policy (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines) was in place for the safe management of vaccines.

All medicines that we checked were found to be in date. The fridges used for the storage of the vaccinations were designated pharmaceutical fridges. The electricity plugs for the fridges were located out of sight behind the fridges which reduced the risk of them being inadvertently disconnected

GPs reviewed their prescribing practices as and when medication alerts or new guidance was received. We saw from data produced at CCG level that audits were carried out by the CCG medicines management pharmacist to optimise the prescribing of certain medicines such as antibiotics or medicines for patients with long term conditions.

Patient medicine reviews were undertaken on a regular basis in line with current guidance and legislation depending on the nature and stability of their condition.

All prescriptions were reviewed and signed by a GP before they were given to the patient or sent electronically to the pharmacy chosen by the patient. The nurse practitioner was appropriately trained to prescribe some medicines. The practice had a protocol for repeat prescribing which was in line with the General Medical Council (GMC) guidelines. This covered how staff who generate prescriptions were trained and how changes to patients' repeat medicines were managed. The practice processed repeat prescriptions within 24-48 hours. Patients confirmed requests for repeat prescriptions were dealt with in a timely way. Systems were in place for reviewing and re-authorising repeat prescriptions, providing assurance that they always reflected the patients' current clinical needs.

Security measures were in place for prescriptions within the practice, access was in line with suggested best practice within the NHS Protect Security of prescription forms guidance, August 2013. We were told hand written prescriptions were rarely used other than on home visits however these were not tracked fully. The practice assured us after discussion they would ensure all prescription numbers from these pads were recorded and audited on a monthly basis.

Emergency medicines for cardiac arrest, anaphylaxis, meningitis and hypoglycaemia were available within the practice. We checked the emergency drug cupboards and boxes and saw that medicines were stored appropriately and were in date. We found the practice had a defibrillator available and access to oxygen for use in emergency. We saw other medicines stored within the practice were in date and robust systems to check expiry dates were implemented. There were procedures to ensure expired and unwanted medicines were disposed of in line with waste regulations.

GPs did not take emergency drugs out in their home visit bags; this had been risk assessed and due to the prompt ambulance response times within the area it had been

decided that the action in event of emergency during a home visit was to call 999 for paramedic assistance. All GPs carried mobile phones in case the patient did not have a phone line at their home. The nursing team had a stocked anaphylaxis medicine box which they took out when visiting patients in their home for flu vaccinations. This was checked and was all in date.

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. Comments recorded by patients on CQC comment cards referred to the practice as being clean hygienic and safe.

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. Staff received training about infection control specific to their role The lead for infection control checked and audited the practice to ensure staff followed procedures. Any actions from the audit had been actioned in a timely manner. Staff understood their role in respect of preventing and controlling infection. For example reception staff could describe the process for handling submitted specimens.

We inspected treatment and clinical rooms. We saw that all areas of the practice were clean and processes were in place to manage the risk of infection. We noted that all consultation and treatment rooms had adequate hand washing facilities. Instructions about hand hygiene were available throughout the practice with hand gels in clinical rooms. We found protective equipment such as gloves and aprons were available in the treatment/consulting rooms. Couches and privacy curtains were washable in the treatment rooms and cleaned following each use. Some chairs within the practice (mainly the GP/ clinical staff chairs) were covered with a material cover these were being replaced over time to ensure they were made of a wipe-able fabric.

We were told the practice only used instruments that were single use. Procedures for the safe storage and disposal of instrumentation, sharps and waste products were evident. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Equipment

Staff we spoke with told us they had sufficient and suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments.

All equipment was tested and maintained regularly and we saw equipment maintenance logs, contracts and other records that confirmed this. Contracts were in place for annual checks of fire extinguishers and portable appliance testing (PAT). We saw that annual calibration and servicing of medical equipment was up to date.

Emergency drugs were stored appropriately. There was an oxygen cylinder, nebulisers and access to automated external defibrillators available at the surgery. These were maintained and checked regularly.

Staffing and recruitment

Our previous inspection had highlighted some areas the practice needed to address in relation to staffing and recruitment. We found these areas had been addressed fully.

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.

There was a system in place to record and check professional registration of the General Medical Council (GMC) and the Nursing Midwifery Council (NMC). We saw evidence that demonstrated professional registration for clinical staff was up to date and valid.

Staff told us there were enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. Procedures were in place to manage expected absences, such as annual leave, and unexpected absences through staff sickness. The staff worked well as a team and as such supported each other in times of absence and unexpected increased need and demand. The practice manager and GP oversaw the rota for clinicians and we saw they ensured that sufficient staff were on duty to deal with expected demand including home visits and chaperoning.

The practice had developed clear lines of accountability for all aspects of care and treatment. Clinical staff had lead

Good

Are services safe?

roles for which they were appropriately trained. The diversity and skill mix of the staff was good; each person knew exactly what their role was and undertook this to a high standard. Staff were skilled and knowledgeable in their field of expertise and were able to demonstrate how they could support each other when the need arose. Some staff had dual roles that encompassed both clinical and administrative aspects.

As a teaching practice the GPs had mentorship roles with the doctors training in their practice. Similarly the Nurse Practitioner had been successful in attracting Student Nurse placements for 12 weeks at a time from the local University. Two student nurses had completed their placements and had given positive feedback from the experience.

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. All new employees working in the building were given induction information for the building which covered health and safety and fire safety. All staff had access to a staff handbook.

There was a health and safety policy available for all staff which included both general workplace and clinical policies and procedures for staff follow.

There was a fire risk assessment in place and the practice regularly had fire equipment tested. Records of fire equipment safety checks and fire drills to ensure the safety of patients, staff or visitors were available.

Arrangements to deal with emergencies and major incidents

Staff could describe how they would alert others to emergency situations by use of the panic button on the computer system.

An appropriate business continuity plan was in place. This comprehensive plan covered business continuity, staffing, records/electronic systems, clinical and environmental events. Key contact numbers were included and paper and electronic copies of the plan were kept in the practice. Staff we spoke with were knowledgeable about the business continuity plans and could describe what to do in the event of a disaster or serious event occurring.

Staff had received training in dealing with medical emergencies including cardiopulmonary resuscitation (CPR). This was updated annually. There was suitable emergency equipment.. 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 and suspected meningitis. 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.

There was a current fire procedures policy in place which identified key personnel, such as fire marshals and their duties in the event of a fire. Weekly fire alarm tests were carried out and equipment maintained by a contracted company.

A designated first aider was identified within the practice.

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 health care assistants and cardiovascular and other regular health checks and screenings were ongoing in line with national expectations.

People with long term conditions were helped and encouraged to self-manage, and checks for blood counts, blood pressure and general wellbeing had been combined into single appointments to create a holistic approach.

Care plans had been put in place for 2% of the practice patients who met the criteria to avoid unplanned admissions to hospital. This was part of local enhanced services and GPs had initiated the plans with patients in their own home and included their family and/or carers where appropriate.

Read coding was extensively used for patients. Read coding records the everyday care of a patient, including family history, relevant tests and investigations, past symptoms and diagnoses. They improve patient care by ensuring clinician's base their judgements on the best possible information available at a given time. The GPs and nurses we spoke with were all familiar with read coding and its benefits when assessing patients' conditions.

Multi-disciplinary meetings were held regularly to discuss patients 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

The practice had a system in place for completing clinical audit cycles. Examples of clinical audits included evaluations of medicines for people with high blood pressure where treatment was changed if required so that the best outcomes could be achieved. Further audits of minor surgery results were planned for the future.

The practice reviewed patients under a locally enhanced service to minimise unplanned admissions to hospital. Where gaps in service provision were found action was taken so as to improve the patient experience. For example patients were signposted to other agencies who could be contacted prior to attendance at accident and emergency departments.

The practice was currently piloting having a Community Psychiatric Nurse (CPN) on the staff at the surgery for two days per week. This allowed them to follow up in a timely manner the attendance of patients from the practice who attended the local NHS A&E department for Mental Health related needs. The CPN will ring the patient as soon as possible after the visit to A&E to offer support and guidance at the surgery. It was hoped this would demonstrate the attendance of this group of patients at A&E would decline over time. The CPN was seeing patients that would otherwise have had to be referred on to local Mental health Trust. The current waiting time for counselling is 11 weeks, Cognitive Behavioural Therapy is 13-17 weeks and for appointments with the psychological wellbeing practitioners in Preston was 15-22 weeks. The CPN could see them within a week and offer assistance and support.

One of the GPs undertook minor surgical procedures within the practice in line with their registration and NICE guidance. However consent was recorded in a ledger within the treatment room, the patient signed the book as a record of giving their consent. Information regarding the minor surgery was accurately recorded by the GP in the patients' electronic notes but a written consent form identified in the consent policy was not used. The GP assured us from now on he would use the designated forms and have them scanned onto the patient record as an accurate record of consent being obtained.

Regular meetings took place with multi-disciplinary team attendance to share information and provide reflection and learning to the benefit of the patients. We saw evidence of collaborative working with the local hostel managers, drug and alcohol teams, CPN, social workers, school nurses, health visitors, district nurses and palliative care staff which resulted in positive outcomes for the patients concerned.

Effective staffing

All the staff at the practice were very complimentary and satisfied about the training opportunities available to them. Staff undertook mandatory training to ensure they

Good

Are services effective?

(for example, treatment is effective)

were competent in the role they were employed to undertake. In addition to this they were encouraged to develop within that role, and sometimes into other roles more suitable to the requirements of the practice. Most staff were multi-skilled and able to carry out the role of their colleagues as required to cover absence.

Most of the staff were long serving. There was an induction process for new staff which covered the practice ethos, introduction to policies and procedures, medical etiquette and duty of care.

Doctors were revalidated, nurse professional registrations were up to date and appraisals were carried out annually on all staff although we did observe that new staff were not appraised until they had been in post for 12 months to allow them to settle into their new roles.

All patients we spoke with were complimentary about the staff and we observed staff who were competent, comfortable and knowledgeable about the role they undertook.

There was enough staff to meet the demands of the practice at the time of the inspection, however we were told there had been some challenges in recent months with some sickness but the staff had worked together to address this.

Working with colleagues and other services

All the practice staff worked closely together to provide an effective service for its patients. They also worked collaboratively with community services to maintain safe and effective care for their vulnerable patients. Regular communication with the local hostel probationary services, refuge, supported living accommodation managers and social services assisted this process.

Systems were in place to ensure that other services were promptly notified of matters of mutual interest that impacted on patient care. For example, regular updates were sent to the out of hour's service in relation to patients receiving palliative care and if patients had signed Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms.

The practice had a close working relationship with Greater Preston Clinical Commissioning Group (CCG) and worked collaboratively on a number of both national and local initiatives.

Patients we spoke with said that if they needed to be referred to other health providers this was discussed fully with them and they were provided with enough information to make an informed choice. CQC comments cards also confirmed patients felt they had been referred for hospital appointments within an appropriate timescale.

Park View worked closely with a homeless shelter, bail hostel and home for children with autism which were demanding services and required extra work by the whole of the team.

One GP worked with the drug worker for substance misuse patients seeing them at the surgery. This was beneficial to the patients as they were not attending the local clinics where they may be exposed to the substances they were trying to avoid.

Information Sharing

Information about significant events was shared openly and honestly at practice meetings. The lead GPs attended CCG meetings and shared what they had learned in practice clinical meetings. This kept all staff up to date with current information around local enhanced services, requirements in the community and local families or children at risk.

The practice used both electronic and fax systems to communicate with other providers. For example, they faxed information to the local out of hours provider to enable patient data to be shared in a secure and timely manner. The out of hour's services and other community health staff were alerted to any possible emergencies that could occur out of surgery hours, when a patient's condition had deteriorated.

There was a practice website with information for patients including signposting, services available and latest news. There were numerous information leaflets available within the practice waiting room and at the request of any of the clinicians if a patient required more private information.

Patients were discussed between the practice clinicians and also with other health and social care professionals who were invited to attend meetings.

All staff completed mandatory training which included; information governance (IG) and confidentiality training. We saw the practice staff completed on line IG training which included; records management and the NHS Code of Practice, access to health records.

Good

Are services effective?

(for example, treatment is effective)

Access to patient information was dealt with in accordance with NHS guidelines. The practice follows the guidelines of Caldicott principles, the Data Protection Act (1998) and Freedom of Information Act (2000). This supported staff to ensure that only appropriate and secure information sharing took place when appropriate to do so and that information would not be given to any other bodies without first gaining the patient's consent.

Consent to care and treatment

Staff understood and were trained in requirements around consent and decision making for people who attended the practice. The GPs and the nurses we spoke with described situations where best interests or mental capacity assessment might be appropriate and were aware of what they would do in any given situation.

The practice had a consent policy. Consent to care and treatment was obtained in line with the ethos of legislation and guidance, including the Mental Capacity Act 2005 and the Children Acts 1989 and 2004. Clinical staff told us they had received training in regards to consent and had received formal training for the Mental Capacity Act 2005 (MCA). GPs and clinicians were aware of the MCA and we saw evidence that patients were supported in their best interests, with the involvement of other clinicians, families and/or carers where necessary.

The practice policy explained all areas of consent and GPs referred to Gillick competency when assessing young people's ability to understand or consent to treatment. This meant that their rights and wishes were considered at the same time as making sure the treatment they received was safe and appropriate.

The 2014 national GP patient survey indicated 94% of people at the practice said the last GP they saw or spoke to was good or very good at explaining tests and treatments, 95% said the last GP they saw or spoke to was good or very good at treating them with care and concern and 94% had confidence and trust in the last nurse they saw or spoke to.

Staff informed us they had access to interpreter translation services for patients who needed it. There was guidance about using interpreter services and contact details available for staff to use.

Health Promotion & Prevention

All new patients were offered a consultation and health check with the Health Care Assistant. This included discussions about their environment, family life, carer status, mental health and physical wellbeing as well as checks on blood pressure, smoking, diet and alcohol and drug dependency if appropriate.

The practice website and surgery waiting areas provided various up to date information on a range of topics and health promotion literature was readily available to support people considering any change in their lifestyle. The waiting rooms were well organised with individual boards for individual health issues which were easy to read and had straight forward directions and advice on them.

The practice offered NHS Health Checks to all patients aged 40 to 74 years old.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the practice nurse.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We spoke with four patients whilst in the practice and received seven completed CQC comment cards.

Comments we received were positive about how staff treated patients.

We found there was a strong culture of patient centred care and ensuring a holistic approach to care was delivered by all staff. It was clear staff were motivated to provide the best possible care.

Patients told us they felt listened to and were treated respectfully by staff. Patients said their privacy and dignity was maintained, particularly during physical examinations.

All patient appointments were conducted in the privacy of a consultation or treatment room. There were privacy curtains for use during physical and intimate examinations and a chaperone service was available. Staff informed us they were aware there was a room available if patients or family members requested a private discussion.

The patient electronic system included flags on patient records to alert staff to patient needs that might require particular sensitivity. For example, learning disability or if they had had a recent bereavement.

We were told by a member of the patient participation group (PPG) the practice listened to their comments; even though they were a virtual group they felt they could influence changes in the practice in the future.

Care planning and involvement in decisions about care and treatment

Patients we spoke with and CQC comments cards we received confirmed that they felt involved in decisions about their care and treatment. Patients told us treatment options was clearly explained and they did not feel rushed and felt able to come away from an appointment to think about matters before deciding what they would like to do. Another patient said the GP always took time to understand and discuss their issues, and answer any questions they may have.

Care plans were in place for patients on palliative care and the GP supported patients with discussion about end of life preferences as appropriate. These care plans were kept up to date and shared with relevant healthcare professionals such as the out of hours (OOHs) service.

Using a coding system on the computer system the practice maintained registers of patients with particular conditions or vulnerabilities, for example, diabetes, mental health issues and learning disabilities. With the involvement of the patient, care plans had been put in place for anyone at increased risk of admission to hospital.

All the staff we spoke with were effective in communication and all knew how to access an interpreter if required. Literature could be accessed in different languages as and when required.

We looked at the consent policy and spoke with clinical and administration staff about consent. We saw the policy provided clear guidance about when, how and why patient consent should be requested. There was reference to children under the age of 16, patients with limited capacity and chaperoning requirements. All clinical staff had completed training regarding the Mental Capacity Act 2005 appropriate to their roles.

The 2015 GP patient survey reported that 94% of respondents said the last GP they saw or spoke to at the practice was good at involving them in decisions about their care. 89% of respondents said the last nurse they saw or spoke to at the practice was good at involving them in decisions about their care.

Patient/carer support to cope emotionally with care and treatment

The practice had systems in place that reflected best practice for patients nearing the end of their life and demonstrated an ethos of caring and striving to achieve dignified death for patients. We were told that in appropriate cases GPs had conversations around end of life planning such as advance care plans, preferred care priorities and resuscitation with patients. This was to ensure patient's wishes were managed in a sensitive and appropriate way. The practice was using the new Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) forms which are valid follow the patient through any health care environment.

Good

Are services caring?

Multi-disciplinary supportive care meetings were held to discuss the needs of those approaching end of life. Patient preferences were shared electronically with appropriate healthcare partners to ensure they were met, for example, with the out of hour's services.

The practice had a display of information dedicated to carers which provided signposting to support on a wide variety of issues.

The 2015 GP patient survey reported that 96% of respondents said the last GP they saw or spoke to at the practice was good at listening to them. 87% said the last nurse they saw or spoke to at the practice was good at listening to them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Park View Surgery offered regular reviews of long term conditions such as chronic heart disease, diabetes and chronic obstructive pulmonary disease. These were undertaken annually or as required with alerts identified on the practice system for when recalls were due.

The NHS Local Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and had identified service improvement plans. This had included improving access to the service for patients for appointments. Late extended opening times had been implemented specifically for those patients who worked alongside two clinics on Saturday morning.

The practice was pro-active in contacting patients who failed to attend vaccination and screening programmes and worked to support patients who were unable to attend the practice. For example, patients who were housebound were identified and visited at home by the practice nurses to receive their influenza vaccinations.

Practice staff pro-actively followed up information received about vulnerable patients.

Patients were able to access appointments with a named doctor where possible. Where this was not possible continuity of care was ensured by detailed electronic records between the clinical team members.

Longer appointments could be made for patients such as those with long term conditions, learning disabilities or who were carers.

One GP worked with the drug worker for substance misuse patients, seeing them at the surgery on a monthly or weekly basis. This was beneficial to the patients as they were not attending the local clinics where they may be exposed to the substances they were trying to avoid.

The practice had also implemented suggestions for improvements where possible in response to feedback from the virtual patient participation group (PPG). A member of the PPG told us the practice was proactively trying to gain feedback from patients and trying to encourage more patients to join the group in order to determine how to improve and meet the needs of the population it served.

Tackling inequity and promoting equality

Action had been taken to remove barriers to accessing the services of the practice. The practice had taken into account the differing needs of people by planning and providing care and treatment service that was individualised and responsive to individual need and circumstances.

The practice provided disabled access in the reception and waiting areas, as well as to the consulting and treatment rooms via a stair lift if required. There was a large waiting area for patients attending an appointment car parking was available nearby but not on site. Baby changing and disabled toilet facilities were available.

The practice analysed its activity and monitored patient population groups. They had tailored services and support around the practice populations needs and provided a good service to all population groups.

The practice had systems in place to ensure people experiencing poor mental health had received an annual physical health check. The practice took all reasonable measures to ensure high quality of mental health care was available to patients within the limitations of the local service. The practice was currently piloting employing a Community Psychiatric Nurse (CPN) for two days per week to assist patients experiencing a Mental Health Crisis to remain in the community and have support and treatment. The CPN was seeing patients that would otherwise have had to be referred on to local Mental Health Trust and those who had needed during a crisis to visit the Local NHS A&E department.

An interpreter service was available if required via Language Line; however we were told this was seldom used.

Access to the service

Information about access to appointments was available via the practice information leaflet and on the practice web site. The practice operated a choice of same day appointments and those which could be booked in advance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

73.4% of respondents to the 2014 GP patient survey said that they were satisfied with the practice opening times. 80.4% said the practice was easy to getting through to by telephone.

From the CQC comment cards completed and speaking with patients we were told appointments were usually on time with not too much waiting. They did also say they were confident if they needed seeing on the day they would be seen at some point.

Late evening appointments via an extended surgery were available on Monday until 8pm. These appointments were aimed at patients who struggle to see a doctor due to work commitments. Appointments were also available on Saturday morning for two clinics from 9am – 12md. Patients could also pre book appointments up to two weeks in advance.

Priority was given to children; babies and vulnerable patients. These patients were always offered a same day or urgent appointment. The nurse practitioner also saw patients with acute health care needs. Home visits were arranged as required with the practice carrying out 10-15 per week to the local community.

GP appointments were provided in 10 minute slots. Where patients required longer appointments these could be booked by prior arrangement. Staff confirmed that longer appointment times were always allocated for patients with multiple long term conditions or for patients with learning difficulties and mental health issues to ensure time was appropriately spent with patients.

Listening and learning from concerns and complaints

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

We reviewed how the practice managed complaints within the last 12 months. Five complaints had been made by patients or family of patients. We found the practice handled and responded to complaints well. Complainants did not receive acknowledgement of the complaint in line with the policy nut the practice manager assured us she would start this process. Complaints were investigated and documented in a timely manner as required.

Investigations addressed the original issues raised and action was taken to rectify problems.

Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had needed to make a complaint about the practice.

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

Park View Surgery did not have a written strategy however it was evident that all staff within the practice worked to the same ethos. Staff had been working at the practice for a number of years and had been part of the changes, challenges and development required to meet demand in the last few years.

All staff were clear on their roles and responsibilities and each strived to offer a friendly, caring good quality service that was accessible to all patients.

There was an established leadership structure with clear allocation of responsibilities amongst the partner GPs and the practice staff. We saw evidence that showed the GPs and practice manager met with the Clinical Commissioning Group (CCG) on a regular basis to discuss current performance issues and how to adapt the service to meet the demands of local people.

As a teaching practice the GPs had mentorship roles with the doctors training in their practice. Similarly the Nurse Practitioner had been successful in attracting Student Nurse placements for 12 weeks at a time from the local University. Two student nurses had completed their placements and had given positive feedback from the experience.

Governance arrangements

There were clear lines of responsibility and accountability for the clinical and non-clinical staff. The practice held regular clinical meetings. Non clinical meetings were diarised monthly but were not formally recorded at the time of the inspection.

We looked at minutes from recent clinical meetings and found that performance, quality and risks had been discussed. The minutes showed what actions needed to be taken and who was responsible.

It was evident that staff were able to raise concerns in a constructive and fair manner. Staff were able to describe how they would raise any concerns and explained how feedback and action was disseminated to staff in a constructive manner.

The practice participated in the Quality and Outcomes Framework (QOF) to measure their performance. The QOF data for this practice showed it was performing well against national standards. We saw that QOF data was regularly discussed at practice meetings and plans were produced to maintain or improve outcomes.

Leadership, openness and transparency

The culture at the practice was open and fair. Staff told us they felt comfortable raising any issues or concerns and that they had the opportunity to discuss with any member of the senior management team.

The practice had advice from an external human resource company and we found there were policies in place to support staff. Staff we spoke with knew where to find these policies if required.

Staff said they were supported in their roles and were able to speak with the practice manager at any given time. They also said they would be happy to speak to any of the GPs if they felt they had any worries.

The practice prided itself on having a 'no blame' culture and staff commented this had not always been the case but they confirmed this was now the current situation.

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

The practice actively sought feedback from patients through patient surveys and complaints received. We looked at the results of the 2014 GP patient survey and the last patient survey conducted by the Patient Participation Group (PPG). Both surveys reflected high levels of satisfaction with the care, treatment and services provided at the practice. However where issues were identified action had been taken to address them. The last friends and family test (Feb 15) completed indicated an 89% positive result for the patient population.

We spoke with a member of the PPG who confirmed the practice and the PPG were continually seeking patients to join the PPG. The group was a virtual group who chose to communicate electronically with each other.

We saw evidence from meeting minutes that the practice did act on feedback and information raised via the PPG.

The practice gathered feedback from all staff grades through discussion and their open door policy. When we looked at staff files it was clear that individual performance was monitored and that personal and professional development was encouraged.

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

GPs were supported to obtain the evidence and information required for their professional revalidation. This was where doctors demonstrate to their regulatory body, The General Medical Council (GMC), that they were up to date and fit to practice. The GPs were involved in the local clinical meetings and one GP led on medicine management for the CCG.

Similarly the practice nurses and practice manager regularly attended their professional forum groups established by the CCG to provide training and support and share good practice.

Nurses were also registered with the Nursing and Midwifery Council, and as part of this annual registration were required to update and maintain clinical skills and knowledge.

The GPs discussed the challenges for services whilst experiencing funding changes however the practice aimed to be innovative and participate in future locality developments.

The practice completed reviews of significant events and other incidents and shared with staff to ensure the practice learned from and took action, which improved outcomes for patients.