Dr MP Vallis & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

Rosedale Surgery has a practice population of approximately 11700 patients. We carried out a comprehensive inspection at Rosedale Surgery on 8 October 2014.

We have rated each section of our findings for each key area. We found that the practice provided a safe, effective, caring, responsive and well led service for the population it served. The overall rating was good and this was because the practice staff were extremely well organised which, led to a very efficient service. Each senior member had dedicated roles. Improvements had been identified and made that had a positive impact on patient care. For example, longer appointment times were provided for patients with long term conditions such as diabetes and vulnerable patients who had learning disabilities.

Our key findings were as follows:

- We found evidence that the practice staff worked together to make ongoing improvements for the benefit of patients.
- Each day there was an assigned duty doctor to respond to any unexpected peaks in patient requests to be seen. The feedback we received from patients informed us they could get appointments when they needed to.
- The practice was able to demonstrate a good track record for safety. Effective systems were in place for reporting safety incidents. Untoward incidents were investigated and where possible improvements made to prevent similar occurrences.
- We found that patients were treated with respect and their privacy was maintained. Patients informed us they were satisfied with the care they received. One comment card we received stated; 'Excellent service at all times.'

We saw an areas of outstanding practice:

- The practice was exceptionally well organised and this resulted in an efficient service that was well led for the benefit of patients.

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 safe. Staff understood and fulfilled their responsibilities to raise concerns, and report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for effective. Our findings at inspection showed systems were in place to ensure that all clinicians were not only up-to-date with both the National Institution for Care Excellence (NICE) guidelines and other locally agreed guidelines but we also saw evidence that confirmed that these guidelines were influencing and improving practice and outcomes for their patients. We saw data that showed that the practice was performing highly when compared to neighbouring practices in the CCG. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for caring. Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions. Accessible information was provided to help patients understand the care available to them. We also saw that staff treated patients with kindness and respect ensuring confidentiality was maintained.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP and continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. There was 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.

Summary of findings

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. We found there were high levels of constructive staff engagement and a high level of staff satisfaction. The practice sought feedback from patients, which included using new technology, and had a very active patient participation group (PPG) and the virtual group.

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. The practice had a higher than average older population and there was a strong relationship with the Community Matron for identifying vulnerable patients at home. Nationally reported data showed 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 people in its population and had a range of enhanced services, for example in dementia and end of life care. The practice was responsive to the needs of older people, including offering home visits and rapid access appointments for those with enhanced needs and home visits.

People with long term conditions

Good

The practice is rated as good for the population group of people with long term conditions. Emergency processes were in place and referrals made for patients in this group that had a sudden deterioration in health. When needed longer appointments and home visits were available. All these patients had a named GP and structured annual reviews to check their health and medication needs were being met. For those people with the most complex needs the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. The practice had Gold Standard Framework of palliative care and Macmillan nurses attended the monthly multiagency meetings.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-up children living in disadvantaged circumstances and who were at risk. For example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us and we saw evidence that children and young people were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Child vaccinations could also be provided by practice nurses during the extended opening hours. We were provided with good examples of joint working with midwives, health visitors and school nurses. Same day appointments were given when parents requested appointments for their children.

Summary of findings

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). The needs this population had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offer continuity of care. To accommodate the working age population there were extended surgery hours from 7am and evening appointments until 8:30pm every Wednesday. The practice was proactive in offering online services as well as a full range of health promotion and screening which reflected the needs for this age group. There was a high uptake for cervical screening. Sexual health advice was given to all age groups.

Two GP's provided a service to sea farers who came to Lowestoft and Life Boat service staff. People who used the temporary caravan facilities in the areas were seen as temporary patients.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of people who varied in age. The practice held a register of patients living in vulnerable circumstances including those with learning disabilities. The practice had carried out annual health checks for people with learning disabilities and there was a robust system in place for DNA's to encourage them to attend for their health checks. Appropriate organisations were informed if patients with learning disabilities failed to attend. The practice used the Cardiff Health Check system to ensure that health reviews were comprehensive. The unplanned admission service identified those vulnerable patients who frequently attended A&E or had unplanned hospital admissions. In these instances the circumstances were explored and where necessary action taken. Practice nurses visited housebound patients and carried out regular reviews.

The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of people experiencing poor mental health (including people with dementia). All patients experiencing poor mental health had been offered annual physical health checks. These invitations were sent by letter or telephone and telephone reminders were sent the day prior to

the appointment. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health including those with dementia. All staff had received training in the Mental Capacity Act 2005 so they would have appropriate skills for dealing with patients with dementia.

The practice worked closely with the local provider of Mental Health Support for appropriate patients. Mental health care plans were completed for some patients.

Summary of findings

What people who use the service say

We spoke with 11 patients during our inspection who varied in age. Some had been registered with the practice for many years. They informed us that staff were polite, helpful and knowledgeable about their needs. Patients told us they were given enough explanations so they understood about their health status and felt they were encouraged to make decisions about their care and treatment. They all reported they were happy with the standards of care they received. We were told it was easy to obtain repeat prescriptions. We did not receive any negative comments from the patients we spoke with.

We collected 20 Care Quality Commission comment cards from a box left in the surgery prior to the inspection. All comments made were very positive, none were negative. One patient described their care as first class and that all staff were very caring and helpful and that staff always listen. The comment cards told us reception staff were pleasant, friendly and helpful both on the telephone and face to face. Another patient advised that their confidentiality was always maintained and there was a good balance between a respectful and friendly approach.

The Patient Participation Group (PPG) had carried out an annual survey. PPG's are an effective way for patients and surgeries to work together to improve services and promote quality care. The outcomes in the report dated 2014 to 2015 were positive. The report contained the comments that patients had made and any recommended improvements that could be made. We spoke with the chair and vice chair of the PPG who told us that the management team liaised well with the group to look at ways to further develop and improve the service patients received.

Outstanding practice

The practice was exceptionally well organised and this resulted in an efficient service that was well led for the benefit of patients. We found that the practice manager was well organised and this assisted the senior team in working together and within their respective disciplines in delivering a good quality service.

Dr MP Vallis & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a Specialist advisor who had experience in practice management.

Background to Dr MP Vallis & Partners

Dr MP Vallis and Partners (Rosedale Surgery) served approximately 11700 patients.

At the time of our inspection there were eight GP partners at the practice, some of these worked on a part time basis. There were three female doctors. The partners provided 23 sessions per week and further sessions were provided by Registrars. Registrars were qualified doctors who were undertaking further training to become a GP. Rosedale Surgery is a training practice. There was a nurse practitioner and a nurse prescriber, three practice nurses and a health care assistant who were employed to work varying hours. The practice manager, assistant practice manager, business manager and reception manager were for the management of 12 reception/administration staff who were also employed to work varying hours.

The practice offered a range of clinics and services including chronic disease management, cervical smears, contraception, minor surgery, diabetic nurse specialist, dressings, injections and vaccinations. Practice staff provided health advice to patients and there were smoking cessation clinics.

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.

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)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 8 October 2014. During our visit we spoke with a range of staff including three GP's, a GP Registrar, a nurse prescriber,

Detailed findings

a practice nurse, the practice manager, one administrator and three reception staff. We also spoke with patients 11 who used the service and chair and vice chair of the Patient Participation Group (PPG) who acted as patient advocates in driving up improvements. We observed how people were being cared and how staff interacted with them and reviewed personal care or treatment records of patients. We reviewed 20 comment cards where patients and members of the public shared their views and experiences of the service.

Good

Are services safe?

Our findings

Safe Track Record

The practice was able to demonstrate it had a good track record for safety. Practice staff used a range of information to identify risks and improve quality in relation to patient safety. For example, reported incidents and national patient safety alerts. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. For example a requested blood that had not been done for a patient in a care home. As a result the system for blood tests of people living in care homes was changed to prevent a recurrence.

We reviewed safety records and incident reports and saw how the practice manager recorded incidents and ensured they were investigated. The partners held an annual meeting to review the practice's safety record over the previous year and to check that the actions taken had been effective.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff recorded incidents as soon as they occurred. The practice manager formally recorded the incidents ready for investigations to be carried out.

There was evidence that appropriate learning had taken place and that the findings were disseminated to relevant staff. The practice staff had notified the Clinical Commissioning Group (CCG) of individual events. The CCG are responsible for monitoring the standards of the services provided by practices.

We were given some sample significant event audits. These clearly stated the investigations carried out, the resultant actions and which staff the information had been cascaded to. The records we saw told us they had been completed in a comprehensive and timely manner.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. Practice training records made available to us showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours.

The practice had dedicated GP's appointed as leads in safeguarding for vulnerable adults and children who had been trained and demonstrated they had the necessary skills to identify abuse and take appropriate action. All staff we spoke with were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

A chaperone policy was in place and visible in the waiting areas. Chaperoning was provided by clinical staff and if they were not available reception staff carried out the role. We found that non-clinical staff had received annual training. We spoke with a receptionist who demonstrated they would carry out the role appropriately.

Medicines Management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check medicines were within their expiry date and safe for use. All the medicines we checked were within their expiry dates. Emergency equipment was also checked to ensure it was in working order.

Vaccines were stored in line with legal requirements and national guidance. We saw recordings that confirmed daily fridge temperatures were recorded to ensure the vaccines were stored at suitable temperatures and remained safe for administration.

There was a protocol for repeat prescribing which was in line with national guidance and was followed by practice staff. Patients who had repeat prescriptions received regular reviews to check they were still appropriate and necessary.

Cleanliness & Infection Control

Good

Are services safe?

We saw that all areas of the practice were clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control. We were shown the cleaning schedule for staff to follow and recordings that had been made where actions were needed by the cleaning staff.

The practice had a lead for infection control who had recently taken on this role. All staff had received training in infection control. The lead had attended further training and was a member of the Royal College of Nursing infection control forum. We saw evidence the lead had carried out monthly audits of the practice and where concerns had been identified they were acted on.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff confirmed there were always good stocks of PPE within the practice. There was also a policy for needle stick injury.

Equipment

Staff we spoke with told us they had sufficient equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and appropriate recordings maintained.

Staffing & Recruitment

Senior staff based staffing requirements on the current demands of patient care. Regular consideration was given by checking whether enough GP sessions were available to meet patient demands. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there was enough staff on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. Patients told us they did not have difficulties in obtaining appointments when they needed to.

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 via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Monitoring Safety & Responding to Risk

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

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, practice staff monitored repeat prescribing for people receiving medication for mental health needs.

Arrangements to deal with emergencies and major incidents

We saw the business continuity plan. The document detailed the actions that should be taken in the event of a major failure and contact details of emergency service that could provide assistance. Copies of the document were held off site by senior staff to ensure it was accessible at all times. The document covered eventualities such as loss of computer and essential utilities. The plan was clear in providing staff guidance about how they should respond.

A fire risk assessment had been undertaken that included actions required for maintaining fire safety. We saw records that showed staff were up to date with fire training and that regular fire drills were undertaken.

Good

Are services safe?

Risks assessments associated with the premises had been carried out and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this and the mitigating actions that had been put in place to manage this.

The patient leaflet gave information about how to access urgent medical treatment when the surgery was closed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their treatment approaches. They were familiar with current best practice guidance accessing guidelines from the National Institute for Care Excellence (NICE) and from local commissioners. We saw minutes of practice meetings where the practice's performance and patients were discussed and required actions agreed. The staff we spoke with told us these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed, in line with NICE guidelines, thorough assessments of patients' needs and these were reviewed when appropriate.

We saw no evidence of discrimination when making care and treatment decisions. Our interviews with the GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

The GPs told us they led in specialist clinical areas such as diabetes, family planning and prescribing. Two nurses were prescribers and there was a diabetic specialist nurse employed. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. The review of the clinical meeting minutes confirmed this happened. Practice staff were participating in a trial regarding the possible introduction of a cancer matron.

Management, monitoring and improving outcomes for people

Practice staff actively participated in recognised clinical quality and effectiveness schemes such as the national Quality Outcomes Framework (QOF) and the local Clinical Commissioning Group (CCG) enhanced service schemes. These schemes have a financial incentive to help improve the quality of clinical care. We were shown the latest QOF achievements that told us practice staff were meeting all of the national standards.

Practice staff had a system in place for carrying out clinical audits. Examples included gestational diabetes and hormonal contraceptives in women aged 45+ years. We saw that both audits had resulted in changes to GP practices regarding prescribing and monitoring systems. We saw examples of where audits had been repeated to check that the changes made from previous audits had been effective.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how as a group they reflected upon the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around quality improvement such as managing patients with diabetes.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending the training courses such as annual basic life support. All GPs had completed their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually and every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. We saw that nurse's appraisals were carried out by clinical staff so that their practices could be discussed and checked. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example specialist diabetes training for one of the practice nurses. The practice was a training practice, doctors who were in training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. Feedback from those trainees we spoke with was positive.

Working with colleagues and other services

There was evidence of appropriate multidisciplinary team working and it was evident there were strong relationships in place. A multidisciplinary meeting was held every month to discuss patients receiving end of life care and those considered to be at risk. Community staff attendance included Macmillan nurses, the community matron and district nurses.

Good

Are services effective?

(for example, treatment is effective)

There was engagement with other health and social care providers to co-ordinate care and meet patient's needs. The practice manager told us the community matron visited the practice approximately three times a week to liaise with staff. District nurses also regularly visited the practice.

The practice was not funded to employ a phlebotomist. Patients went to the local hospital for their blood tests. Patients were invited to contact the practice to receive their results. However, if a test was abnormal, patients would be contacted and informed by the GP either face to face or by telephone consultation.

Information Sharing

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

For patients who had attended an out of hours service or following discharge from hospital we were told that the respective GP reviewed the information provided to them on a daily basis. A GP told us that if patient's required follow up they would send a request to the patient for them to make an appointment. If necessary a referral would be made to a hospital or physiotherapist.

Consent to care and treatment

We spoke with 11 patients and they all confirmed they felt in control of the care because they had been well informed about their illnesses and treatment options. We saw evidence that patients who had minor surgery at the practice had been properly informed of the risks and benefits of the procedure. We were told that consent forms were signed only after full explanations had been given to patients.

Clinicians were aware of the requirements within the Mental capacity Act 2005. This was used for adults who lacked capacity to make informed decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity.

They also knew how to assess the competency of children and young people about their ability to make decisions about their own treatments. Clinical staff understood the key parts of legislation of the Children's and Families Act 2014 and were able to describe how they implemented it in their practice. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 years of age who have the legal capacity to consent to medical examination and treatment).

Health Promotion & Prevention

All nursing staff employed at the practice had been trained in health promotion. This enabled them to provide advice when they saw patients. Patients were encouraged to take an interest in their health and to take action to improve and maintain it. We saw a variety a of health and welfare information displayed in the waiting areas informing patients about health promotion and prevention.

The practice manager told us that all new patients were offered a health check and a review of any prescribed medicines they were taking. There was also opportunity to obtain patients medical histories and family histories. The information would include social factors such as, type of employment, smoking and alcohol consumption. We were told that health advice and literature was given to patients as required.

The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. For example, the practice kept a register of all patients with learning disabilities (LD) and they were offered an annual physical health check. We were told by a practice nurse those patients who did not attend (DNA) or their families or carers would be contacted. If the DNA persisted the practice nurse told us they would pass on the information to the LD community team.

The practice's performance for cervical smear uptake was better than others in the CCG. The latest Quality Outcome Framework (QOF) figures told us the practice had gained the maximum number of points. A GP told us this achievement had remained consistent each year.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

We found that staff upheld and maintained the privacy and dignity of patients. A policy was available in respect of equality and diversity. We observed that when patients arrived staff greeted them in polite and helpful manner All of the 11 patients we spoke with told us staff were friendly and professional towards them. They told us the reception staff were courteous and helpful. Some comments made in the comment cards we received displayed their satisfaction with the way that reception staff greeted them.

Window blinds and privacy screens were in each consulting room. A nurse told us they were always used and the door closed before personal procedures were carried out. Patients we spoke with told us their privacy was always protected.

The practice had a chaperone policy and patients told us they were aware of their right to request a chaperone.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

Reception staff told us they would offer to take patients into an unoccupied room if they needed to hold a confidential conversation. This prevented patients overhearing potentially private conversations between patients and reception staff.

Care planning and involvement in decisions about care and treatment

Patients were given the time they needed and were encouraged to ask questions until they understood about their health status and the range of treatments available to them. The patients we spoke with told us they were able to make informed decisions about their care and felt in control.

The Mental Capacity Act 2005 governs decision making on behalf of adults and applies when patients did not have mental capacity to make informed decisions. Where necessary patients had been assessed to determine their ability prior to best interest decisions being made. Staff we spoke with had an awareness of the Mental Capacity Act and had received training.

A practice nurse told us they explained tests and treatments to patients before carrying them out and ongoing information was provided during the procedures so that patients knew what to expect.

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and patient website signposted people to a number of support groups and organisations. We saw a number of leaflets in the waiting areas for patients to pick up and take away with them. They informed patients of various support groups and their contact details. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. Staff had a system for identifying those people who were carers to enable them to monitor if carer's needed assistance. Clinical staff identified the isolation and risk factor of older patients and offered them directions for obtaining assistance.

The respective GP contacted bereaved families and offered them contact details of support agencies. They were offered the opportunity to speak with the GP or a nurse whenever they wanted to.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice staff recognised the long term condition needs of its practice population. For example, diabetes. A GP took a particular interest in this group of patients and a nurse had received specialist training in this aspect of care.

We saw the patient Participation Group (PPG) report for 2014 to 2015. PPG's act as representative for patients and work with practice staff in an effective way to improve services and promote quality care. Individual patient comments from the surveys had been recorded in the report. The report informed us that patients were satisfied with the service they had received. From this the PPG were meeting with senior staff and discussions were in progress to implement a system of staff champions such as disabilities.

Patients requiring specialist investigation or treatment were referred to hospitals. Patients we spoke with told us they had been given choices about where they wished to be referred to. Patients told us their referrals had been carried out effectively and promptly. There was also a 'choose and book' system so that patients could review the waiting times at various hospitals before making their decisions about where they wanted to be seen.

Patients who requested a home visit were contacted by telephone by a GP to check the visit was essential. Home visits were made on the same day they had been requested. Regular home visits were made by GP's and nursing staff to patients who were housebound.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Two GP's had developed and provided a service to sea farers and Life Boat service staff. People who used the temporary caravan facilities in the locality were seen as temporary patients.

A number of staff employed at the practice spoke various languages. Staff told us that translation services were available for patients who did not have English as a first language.

The premises were accessible by patients who had restricted mobility. There was a toilet for disabled people and another was in the process of being constructed during our inspection. The corridors and doorways to consulting rooms were wide enough to accommodate wheelchairs. All consulting rooms were located on the ground floor.

The practice had equality and diversity policy and staff were aware of it. Patients we spoke with did not express any concerns about their rights about how they were treated by staff.

Access to the service

Appointments were available each weekday mornings and afternoons. Every Wednesday appointments were available from 7am and the afternoon clinic extended to 8:30pm. Reception staff told us children would always be seen on the day an appointment was requested.

Comprehensive information was available to patients about appointments on the practice website and in the practice leaflet. This included how to arrange urgent appointments and home visits and how to book appointments through the website. 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.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor of their choice.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. One comment card told us a patient had requested an urgent appointment for severe pain. They were given an appointment for 20 minutes later. The patient needed to be seen again and was given an appointment for 30 minutes later. This meant staff prioritised according to patient's needs.

Listening and learning from concerns & complaints

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

handles all complaints in the practice. The practice leaflet informed patients about how to make a complaint if they needed to and there were separate leaflets about complaints available at the reception desk.

The practice staff had a system in place for handling concerns and complaints. We were shown a summary of the complaints received during the last 12 months. We saw they had been investigated, responded to and there were instances where changes had been made to prevent recurrences. Practice staff told us that the outcome and any lessons learnt following a complaint were disseminated to relevant staff and discussed during meetings.

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 was evident that senior staff had continued to search for further areas of improvement on an ongoing basis. The minutes from meetings held with the Patient Participation Group (PPG) informed us of areas where further improvements were being made. For example developing staff champions and the systems for obtaining hospital appointments for patients.

We spoke with 12 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They told us they felt all staff worked as a team and were encouraged to make suggestions that led to improved systems and patient care.

The local Clinical Commissioning Group (CCG) had asked the practice to provide services to two large care homes as part of an initiative to improve the quality of care and treatments the residents received.

Governance Arrangements

The practice had a clear governance structure designed to provide assurance to patients and the local clinical Commissioning Group (CCG) that the service was operating safely and effectively. There were specific identified lead roles for areas such as prescribing and safeguarding. Responsibilities were shared among GPs, nurses and the practice manager.

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

Leadership, openness and transparency

We found that the practice manager was very organised and this had cascaded onto other staff in ensuring the day to day operations were carried out effectively. We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with eight members of staff and they were all clear about their own roles and responsibilities. They all told us that felt valued, well supported and knew who to go to in the practice with any concerns.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

At the time of our inspection the provider was not subject to any external peer reviews such as Urgent Health UK (UHUK).

Practice seeks and acts on feedback from users, public and staff

The practice had an active Patient Participation Group (PPG). The PPG had carried out annual surveys and met every quarter. PPG's act as representative for patients and work with practice staff in an effective way to improve services and promote quality care. The practice manager showed us the analysis of the last patient survey which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

We spoke with the chair and vice chair of the PPG. They told us the practice staff worked as team and the PPG had positive working relationships with staff. They informed us that staff made ongoing efforts to improve the quality of the service and constantly searching for ways to improve staff practices. There was a virtual group (communicated with via email) of 87 members. This was set up to capture opinions from younger patients who may work or be at home with children.

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

Management lead through learning & improvement

Staff told us that senior staff supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

Are services well-led?

Good

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

Practice staff had revised and changed the processes for patients with long term conditions. This had resulted in low attendance at A&E and below average admissions between April 2013 and March 2014.

The practice manager told us they regularly checked the appointments system to ensure there were enough to meet patient demands. Patients we spoke with and the comment cards we received informed us they could get appointments when they needed them.

The practice had completed reviews of significant events and other incidents and shared them with staff via meetings to ensure the practice improved outcomes for patients. For example the standards of care provided to patients living in two care homes that practice staff were responsible for.