Milborne St Andrew Surgery

Quality Report

Milton Close Road
Milborne St Andrew
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Milborne St Andrew on 11 July 2016. Overall the practice is rated as outstanding.

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.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice directly employed a member of staff and maintained a suitable vehicle for them to support local patients by delivering medicines to their homes in this rural area.
- Feedback from patients about their care was consistently positive.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- 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. For example, the practice had provided treatment rooms for clinics and resources for the health visitor team at the branch location. The practice had also successfully introduced a phlebotomy service at the branch location as a result of patient feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- This dispensing practice had safe and effective systems for the management and dispensing of medicines, which kept patients safe.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear ethos which had quality and safety as its top priority. The ethos was to provide the highest standard of individualised healthcare in a safe,

Summary of findings

friendly and welcoming environment. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.

- The practice had strong and visible clinical and managerial leadership and governance arrangements.
- The practice provides regulated activities from two locations. The main practice is located at Milton Abbas Surgery, Catherines Well, Milton Abbas, Blandford Forum, Dorset DT11 0AT. The other location is Milborne St Andrew Surgery, Milton Close Road, Milborne St Andrew DT11 0DT. The practice has the same management team, GPs and patient list across both locations. We visited both of these locations during our inspection. This report refers to our inspection of the location at Milborne St Andrew. A separate report which can be found on our website www.cqc.org.uk refers to the other location at Milton Abbas.

We saw several areas of outstanding practice including:

The regular and consistent sharing of best practice with neighbouring practices by forming working groups to discuss significant events, adult and child safeguarding, dispensing, prescribing, and a military veteran's policy.

GPs were open to new ideas and learning by sharing their own annual appraisal outcomes with each other and then using their shared resources to achieve these outcomes and deploying their expertise as a team.

Innovative in providing care and services to its patients by setting up an Integrated Nursing Team (INT) combining the roles of practice and community nurses, carrying out home visits across this large rural area 365 days a year from 8:30am to 5.30pm. The INT supported patients by setting up care packages including physiotherapy and occupational therapy, to help patients avoid an extended stay in hospital.

Successful deployment of a dedicated carer's lead had identified 4% of the practice population as being carers. Carers could make appointments with the carer's lead, receive home visits, and joint visits with GPs. The practice had funded a local gym to support and promote a healthy lifestyle for patients. There was a voluntary patient transport service and an efficient medicine delivery service.

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.

- Outcomes for patients who use services are consistently better than expected when compared with other similar services as shown in the 2015-2016 quality outcomes framework scores.
- Practice staff are committed to working collaboratively, Patients who have complex needs are supported to receive coordinated care and there are innovative and efficient ways to deliver more joined-up care to patients who use services.
- Engagement with stakeholders, including those who use services and those close to them, informs the development of tools and support to aid informed consent.
- Staff are consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with patients is used to do so.
- This dispensing practice had safe and effective systems for the management and dispensing of medicines, which kept patients safe.
- Sharing best practice with neighbouring practices by forming working groups to discuss significant events, adult and child safeguarding, dispensing, prescribing, military veteran's policy.
- Successfully initiated the Multi-Agency Risk Management (MARM) meeting system, a joined up approach with the full range of public services for the benefit of patients.
- During our inspection we found that not all Medicines and Healthcare products Regulatory Agency (MHRA) alerts had been received by the practice. When this was brought to the attention of the practice during the inspection, a new protocol was introduced and we saw evidence that relevant MHRA alert searches were then completed. This ensured any patients affected were identified and appropriate action taken.

Are services effective?

Good

The practice is rated as good for providing effective services.

- There is a holistic approach to assessing, planning and delivering care and treatment to patients who use services. The safe use of innovative and pioneering approaches to care and how it is delivered are actively encouraged.
- New evidence based techniques and technologies are used to support the delivery of high-quality care.

Summary of findings

- All staff are actively engaged in activities to monitor and improve quality and outcomes. Opportunities to participate in benchmarking, peer review and accreditation are proactively pursued. High performance is recognised by external bodies.
- The continuing development of staff skills, competence and knowledge is recognised as integral to ensuring high-quality care. Staff are proactively supported to acquire new skills and share best practice.
- Staff, teams and services are committed to working collaboratively, patients who have complex needs are supported to receive coordinated care and there are innovative and efficient ways to deliver more joined-up care to patients who use services.
- The systems to manage and share information that is needed to deliver effective care are coordinated across services and support integrated care for patients who use services. Consent practices and records are actively monitored and reviewed to improve how patients are involved in making decisions about their care and treatment. Engagement with stakeholders, including those who use services and those close to them, informs the development of tools and support to aid informed consent.
- Staff are consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill-health, and every contact with people is used to do so.
- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice has been using digital photography to aid in the diagnosis of skin conditions for many years. The Practice had been selected By the clinical commissioning group (CCG) to pilot a more formal dermatology photography and referral scheme, thus helping patients avoid waiting for a consultant appointment and a visit to hospital.

Summary of findings

- The practice piloted both a 24 hour echocardiogram (ECG) used to help patients with heart conditions, and a direct access echocardiogram project which provided appropriate rapid access to diagnostic services, facilitating earlier diagnoses in a setting closer to the patients home.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services. Data from the national GP patient survey showed patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently positive.

We observed strong person-centred care:

- Patients are truly respected and valued as individuals and are empowered as partners in their care.
- Feedback from patients who use the service, those who are close to them and stakeholders is continually positive about the way staff treat patients.
- Staff are highly motivated and inspired to offer care, including healthcare, that is kind and promotes people's dignity.
- Relationships between patients who use the service, those close to them and staff are strong, caring and supportive. These relationships are highly valued by all staff and promoted by the partners of the practice.
- Staff recognise and respect the totality of patient's needs. They always take patient's personal, cultural, social and religious needs into account.
- Those who use services are active partners in their care. Staff are fully committed to working in partnership with patients and making this a reality for each person and showed determination and creativity to overcome obstacles to delivering care. Individual's preferences and needs are always reflected in how care is delivered. Individual's emotional and social needs are seen as important as their physical needs.
- Views of external stakeholders were very positive and aligned with our findings.
- The practice had systems in place to identify military veterans and ensure their priority access to secondary care in line with the national Armed Forces Covenant. The practice military veteran's policy had been reviewed in May 2016.
- Successful deployment of a dedicated carer's lead who had identified 4% of the practice population as being carers. Carers could make appointments with the carer's lead, receive home visits, and joint visits with GPs.

Summary of findings

Are services responsive to people's needs?

Outstanding

The practice is rated as outstanding for providing responsive services. We found examples of outstanding responsive services:

- Funded a local gym to support and promote a healthy lifestyle for patients.
- An innovative integrated nursing team (INT) which combined the roles of practice and community nurses, carrying out home visits across this large rural area seven days a week, 365 days a year from 8:30am to 5.30pm.
- Services are tailored to meet the needs of individuals and are delivered in a way to ensure flexibility, choice and continuity of care.
- Individual's needs and preferences are central to the planning and delivery of tailored services. The services are flexible, provide choice and ensure continuity of care.
- The involvement of other organisations and the local community is integral to how services are planned and ensures that services meet patient's needs. There are innovative approaches to providing integrated person-centred pathways of care that involve other service providers, particularly for those with multiple and complex needs.
- There is a proactive approach to understanding the needs of different groups of patients and to deliver care in a way that meets these needs and promotes equality. This includes patients who are in vulnerable circumstances or who have complex needs.
- Patients can access appointments and services in a way and at a time that suits them.
- There is active review of complaints and how they are managed and responded to, and improvements are made as a result. Patients who use services are involved in the review.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs.
- 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. For example, the patient participation group (PPG) had suggested that the practice address the "did not attend" (DNA) rate more closely. The practice had responded to this by displaying the latest did not attend statistics in the waiting room and placed information on the impact of not attending a GP or nurse appointment in the local parish magazine.
- Patients can access appointments and services in a way and at a time that suits them. For example, the practice had consulted

Summary of findings

its patients prior to implementing its extended hours and listened to their views. As a result the practice opened every Saturday morning from 9am to 10.30am in response to patient feedback.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.
- The practice had employed an appropriately qualified delivery driver and maintained a suitable vehicle for them to support local patients by delivering essential medicines to their homes in this rural area, as the practice had recognised that this was a service patients needed. The practice sub-contracted this service out to two other local practices to support their patients.
- The practice had an organised voluntary patient transport service with 35 volunteer drivers. The positive impact on 190 patients in this rural area with poor public transport links was that they could be collected and returned from their home and were able to see practice GPs or nurses face to face in the surgery.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. We found examples of outstanding well led services:

- The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.
- The strategy and supporting objectives are stretching, challenging and innovative, while remaining achievable.
- A systematic approach is taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.
- Governance and performance management arrangements are proactively reviewed and reflect best practice.
- Leaders have an inspiring shared purpose, they strive to deliver and motivate staff to succeed.
- There are high levels of staff satisfaction. Staff are proud of the organisation as a place to work and speak highly of the culture. There are consistently high levels of constructive staff engagement. Staff at all levels are actively encouraged to raise concerns.

Summary of findings

- There is strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.
- Innovative approaches are used to gather feedback from people who use services and the public, including people in different equality groups.
- The practice celebrated safe innovation by producing a colour coded book mark for use by staff during multi-disciplinary meetings on palliative care, to remind staff from different agencies of the gold standard framework for palliative care.
- Accurate and timely data analysis was achieved by the employment of an in house expert, who carried out regular audits and provided advice on how to shape reporting and auditing for the practice and on a wider basis across the clinical commissioning group (CCG) area, by, targeting key improvement areas to help patients.
- GPs were open to new ideas and learning by sharing their own annual appraisal outcomes with each other and then using their shared resources to achieve these outcomes and deploying their expertise as a team.

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

Outstanding ☆

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

- A significant proportion of the practice population was included in this population group. For example, 24.7% of patients were aged over 65 years. This was higher than the national average of 16%.
- The practice had worked with the local community to develop and organise a voluntary transport service called "Neighbourcar" which currently had 35 volunteer drivers and helped to reduce social isolation.
- GPs and the Integrated Nursing Team (INT) shared care provision and treatment for patients, supporting holistic, continuous care.
- The practice supported the initiation of and actively promoted monthly groups which organised social activities aimed at this population group such as 'Milborne Friendly Visitors' which had helped approximately 220 patients to avoid social isolation. This had attracted positive feedback from patients.
- Patients had a named GP. Those at high risk of hospital admission or aged over 75 years were supported by an elderly care nurse who proactively identified vulnerable patients and supported access to clinical and social services.
- The practice held bi-weekly multi-disciplinary, vulnerable adult meetings in order to review patient's needs in a structured way. Records showed regular monthly attendance from other providers to support delivery of holistic person-centred care.
- The practice 'Neighbourcar' is a voluntary transport scheme developed and organised by the practice, which allowed patients to access the practice in this rural area with poor public transport links.
- The practice undertook care planning to support hospital admission avoidance including palliative and end of life care, advanced care planning and having a focus on the patients preferred place of death. The practice team offered bereavement support to families as part of their end of life care. The practice focused on facilitating patients' preferred place of death. Between April 2015 to March 2016, of the 17 patients receiving end of life care from the practice, 70% achieved their preferred place of death, of which 65% died at home. The national average was 33%.

Summary of findings

- The practice worked collaboratively with the local community rehabilitation in-reach nurse on hospital admission avoidance and safe patient discharge from hospital. This helped patients to avoid a prolonged hospital stay.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions.

- The practice Integrated Nursing Team (INT) structure enabled provision of a very high level of care to patients with long term conditions.
- Appointment lengths were varied depending on need and home visits were integral to support patients who were housebound.
- The Integrated Nursing Team undertook assessments in patient's homes to enable a holistic review. Joint visiting of the nurses and GPs for care planning or clinical review of some patients occurred.
- GP's worked very closely with all practice staff, and other primary and secondary care colleagues to meet patient and carer needs.
- The Integrated Nursing Team (INT) had various specialist roles. These included the role of community matron, district nurse and practice nurse. This enabled continuity of care which patients told us they appreciated.
- Vulnerable adult meetings were attended by social workers and community mental health for older people.
- Monthly gold standard framework meetings to discuss palliative care patients (including patients with complex chronic health conditions) were attended by GP's, nurses, the practice dispensary lead and the local community palliative care nurse.
- The practice diabetes nurse lead had established a bi-monthly joint clinic with the hospital diabetes nurse specialist, for the purpose of reviewing complex patients, enabling clinical management discussion and opportunities for reflection and learning.
- The INT lead nurse has completed an initiating insulin course, helping patients onto using insulin where appropriate and supporting them in achieving a greater degree of self-care.

Families, children and young people

Outstanding ☆

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

Summary of findings

- Antenatal and post-natal care was offered for pregnant women, together with child development checks and vaccinations clinics.
- Midwife and health visitor clinics were held weekly.
- Staff were trained to an appropriate level in safeguarding.
- The practice provided healthcare services for the local boarding school, and held specific clinics for students twice weekly during term time. The practice met regularly with the school, had good communications and offered training support and liaison regarding vaccinations. The nurse team conducted asthma clinics at the school.
- GPs offered confidential sexual health advice at the school for 240 pupils aged from 11 to 18 years, chlamydia testing, and emergency contraceptive procedures.
- The practice provided online and text message services for all patients, with planning in progress to target younger people with health messages.
- Child vaccination rates were in line with national averages and had been significantly improved over the last two years and this achievement had been acknowledged by Public Health England. The practice had taken action to focus upon this area through the introduction of a new nurse team lead.
- The practice was actively supporting the development of a play park locally to enable healthy exercise for young people, promotion of health and well-being.

Working age people (including those recently retired and students)

Outstanding ☆

The practice is rated as outstanding for the care of working age people (including those recently retired and students).

- The practice provided extended hours appointments with the GPs and nurses on Saturday mornings from 9am until 12 noon, which were aimed primarily at this population group.
- Online services were provided, including online repeat prescription ordering which had attracted positive feedback from working age patients.
- The practice provided convenient local pick up points for prescriptions in local villages.
- The practice offered NHS health checks and other services appropriate to this population group, including travel vaccinations.

Summary of findings

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

People whose circumstances may make them vulnerable

Outstanding 

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary 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 normal working hours and out of hours.
- The practice held regular vulnerable patient meetings including the local community mental health teams, and undertook regular medicine reviews relevant to this population group.
- The adult and children's GP safeguarding leads supported vulnerable patients.
- The Integrated Nursing Team (INT) allowed flexibility of care delivery for this population group, whilst offering continuity of care.
- The whole team developed relationships with patients, due to being a small team, recognising patients and changes in behaviour to highlight potential issues.
- Knowledge of local social events helped the team to support patient interaction with others.
- The practice offered communication in various ways to support the Accessible Information Standard (AIS). The AIS was created by NHS England and states that by July 2016 patients who have a disability, impairment or sensory loss get information that

Summary of findings

they can access and any communication support that they need. The practice had portable hearing aid induction loop, braille on door signs and appropriate notes on patient records to highlight these needs to practice staff.

People experiencing poor mental health (including people with dementia)

Outstanding ☆

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

- 100% of patients diagnosed with dementia had, had their care reviewed in a face to face meeting in the last 12 months. This was better than the national average of 84%.
- The percentage of patients registered with mental health issues who had a comprehensive, agreed care plan documented in the record, in the last 12 months was 100% which was higher than the CCG average of 92% and national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- The practice carried out advance care planning for patients living with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- The practice audited medicine compliance to identify and follow up patients who failed to collect their medicines or did not attend their appointments.
- Staff had a good understanding of how to support patients with mental health needs and those living with dementia.
- The practice worked with other professionals to provide advice or treatment to patients in this population group.
- The practice offered weekly counsellor appointments on the premises.
- Multi-disciplinary team meetings included patients experiencing poor mental health and those living with dementia whenever possible or appropriate.
- Appointments were adapted to support patients with mental health issues, for example by providing a longer appointment.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 January 2016. The results showed the practice was performing higher than local and national averages. 228 survey forms were distributed and 113 were returned. This represented 3% of the practice's patient list.

- 94% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 83% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 83% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 96% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 98 comment cards which were all positive about the standard of care received. Patients had written about the excellent care provided by GPs and nurses, the friendly and approachable receptionists and described a well organised, clean practice. Patients had also commented on the high levels of dedication of the staff, their patience and positive attitude.

We spoke with three patients during the inspection. All three patients said they were extremely satisfied with the care they received and thought staff were approachable, committed and caring.

Results from the practice's friends and families survey for May 2016 showed that 18 out of 19 patients who responded to the survey were likely or extremely likely to recommend the practice to their friends and family. The practice had a noticeboard for the friends and family which displayed the latest results, patient comments and what action the practice had taken as a result. For example, the practice had acted upon patient feedback through implementing its extended hours on Saturday mornings.

Outstanding practice

The regular and consistent sharing of best practice with neighbouring practices by forming working groups to discuss significant events, adult and child safeguarding, dispensing, prescribing, and a military veteran's policy. GPs were open to new ideas and learning by sharing their own annual appraisal outcomes with each other and then using their shared resources to achieve these outcomes and deploying their expertise as a team.

Innovative in providing care and services to its patients by setting up an Integrated Nursing Team (INT) combining the roles of practice and community nurses, carrying out home visits across this large rural area 365 days a year from 8:30am to 5.30pm. The INT supported patients by setting up care packages including physiotherapy and occupational therapy, to help patients avoid an extended stay in hospital.

Successful deployment of a dedicated carer's lead had identified 4% of the practice population as being carers. Carers could make appointments with the carer's lead, receive home visits, and joint visits with GPs. The practice had funded a local gym to support and promote a healthy lifestyle for patients. There was an organised voluntary patient transport service and an efficient medicine delivery service.

Milborne St Andrew Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser.

Background to Milborne St Andrew Surgery

Milborne St Andrew Surgery was inspected on 11 July 2016. This was a comprehensive inspection.

The main practice is situated in the rural village of Milton Abbas. The practice provides a primary medical service to 3705 patients of a diverse age group. The practice is a teaching practice for medical students, nursing students and a training practice for GP trainees.

The practice nursing team based in this rural area are called an Integrated Nursing Team (INT). The nurses carry out the role of practice nurses, community nurses, palliative care nurses, and community matron. The practice has a dispensary providing pharmaceutical services to patients who lived more than one mile (1.6km) from their nearest pharmacy premises.

There is a team of three GPs partners, one female and two male. Some work part time and some full time. The whole time equivalent is 2.5. Partners hold managerial and financial responsibility for running the business. The team are supported by a practice manager, a deputy practice manager, a nurse prescriber, four practice nurses, two health care assistants, dispensing and additional administration staff.

Patients using the practice also have access to physiotherapists, counsellors, chiropodists, midwives, health visitors and diabetic specialist nurses who visited the practice. Other health care professionals visit the practice on a regular basis.

The practice is open between the NHS contracted opening hours 8am - 6.30pm Monday to Friday. Appointments can be offered anytime within these hours. Extended hours surgeries are offered on Saturday mornings from 8.30am to 10.30am. In addition, the practice integrated nursing team operate seven days a week from 8.30am to 6.30pm.

Outside of these times patients are directed to contact the out of hour's service by using the NHS 111 number. Information for patients on how to access this service is on the practice website, in the practice information leaflets, on signage within the practice, and on the practice answer machine.

The practice offers a range of appointment types including book on the day, telephone consultations and advance appointments.

The practice has a Personal Medical Services (PMS) contract with NHS England.

The practice provides regulated activities from two locations. The main practice is located at Milton Abbas Surgery, Catherines Well, Milton Abbas, Blandford Forum, Dorset DT11 0AT. The other location is Milborne St Andrew Surgery, Milton Close Road, Milborne St Andrew DT11 0DT. The practice has the same management team, GPs and patient list across both locations. We visited both of these locations during our inspection. This report refers to our inspection of the location at Milborne St Andrew. A separate report which can be found on our website www.cqc.org.uk refers to the other location at Milton Abbas.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 28 June 2016. During our visit we:

- Spoke with a range of staff including GPs, nursing, dispensary and administrative staff and spoke with three patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed the personal care or treatment records of patients.
- Reviewed 98 comment cards where patients and members of the public shared their views and experiences of the service.

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)

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

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice had been the first practice in Dorset Clinical Commissioning Group (CCG) to implement a new safeguarding system called the Multi-Agency Risk Management (MARM) meeting system in 2015. MARM introduced a complete joined up approach with all agencies including the Fire and Police services. The impact upon patients was that having so many specialists meeting together meant that more creative and innovative solutions could be found. One example was where the MARM group had identified that a patient had the mental capacity to reach their own decisions as to their preferred place of death. This had been established with the patients, their views recorded and respected as a result of the MARM's actions. Another example was where the practice had found a solution to caring for a patient's dog during their hospital stay. The MARM group worked with the voluntary sector to find a solution for caring for the dog in the patient's absence.

MARM had also been used in cases of domestic violence to consider the impact on all members of the household and apply appropriate interventions. The MARM process was led by this practice had been adopted by other practices across the CCG.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses had been trained to level three child safeguarding and appropriate levels for adult safeguarding. Health care assistants and receptionists had received relevant safeguarding training appropriate to their role.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the practice had refreshed its hand washing signage around relevant

areas, new chairs for the waiting room had been provided which were easier to clean, redecoration of the reception areas had taken place where flaking paint had been identified by the audit.

- The practice accessed available support from the CCG including the local quality team which included examining infection control procedures.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and systems were put in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. Any medicines incidents or 'near misses' were recorded for learning. The practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us the standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). These were being adhered to and staff were familiar with their role and responsibilities in relation to these.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice had a list of which members of staff were trained to carry out certain procedures (such as cervical screening) which ensured that all staff knew and understood their own and other's responsibilities.
- The practice shared best practice on a regular basis with neighbouring practices. For example, they had formed working groups to discuss significant events, adult and child safeguarding, and they had also reviewed and shared their best practice on dispensing and prescribing. The positive impact of this for patients was the constant sharing and updating of best practice and the most up to date safe and effective care and information being provided to patients. For example, the military veteran's policy had been shared with other local practices which supported the armed forces covenant.

Arrangements to deal with emergencies and major incidents

Good

Are services safe?

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as adverse weather, power failure or building damage. The plan included emergency contact numbers for staff. This had been reviewed in June 2016. The practice was part of the local winter planning group in this rural area.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.
- The practice piloted an echocardiogram (ECG) scheme for patients with heart conditions. The scheme was started by this practice in 1998 and has now been adopted across the county. ECG is a heart screening tool which uses high-frequency sound scans to give accurate recording of the heart muscle, the heart chambers, and structures within the heart). To date this service improvement has lead to a reduction in cardiology referrals of 17 % . It provided quick accurate diagnoses in a 'care closer to home' setting. The practice had also set up and piloted a GP direct access echo-cardiology service. Echo-cardiography provides views of the heart muscle, chambers and other structures and facilitates diagnosis. The number of patients who had benefitted through earlier diagnosis and the resulting quicker intervention of appropriate treatment was 68 in the last 12 months. Both of these services provide early diagnosis and therefore support early intervention, in addition to importantly allow care closer to home and reduce secondary care referrals.

- The practice has been chosen by the Clinical Commissioning Group (CCG) to pilot a dermatology photography scheme. Skin lesions are photographed and discussed at practice clinical meetings, and sent to a consultant for specialist diagnosis where necessary, thus helping the patient to avoid waiting for a consultant appointment and a visit to hospital. Approximately 50 patients have benefited from this in the last 12 months. The pilot will be the first step to formalising this process as a commissioned service for all.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from April 2015 to March 2016 were 99% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015-2016 showed:

- The percentage of patients with a diagnosis of diabetes, on the register, who have had influenza immunisation in the preceding 12 months was 97.24% which was comparable with the clinical commissioning group (CCG) average of 97.18% and better than the national average of 94.45%.
- The percentage of patients diagnosed with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 100% which was higher than the CCG average of 92% and the national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been ten clinical audits completed in the last two years, three of these were completed full cycle audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, a patient audit had been completed about how patients used and stored their own medicines. This had found that some patients needed to be further educated in areas such as cold storage of certain medicines and the safe disposal of medicines.
- Findings from medicine audits had resulted in improvements to patient care. For example, a complete cycle pregabalin audit, a medicine used to treat epilepsy, neuropathic pain, and generalized anxiety disorder had identified patients who could benefit from an alternative medicine or an adjustment in their medicine dosage. For example, some patients had

received the benefit of changing to a more appropriate medicine with fewer side effects. These changes had been implemented and the audit repeated every six months.

- A continuous audit of patients who did not fully manage their controlled diabetes was conducted bi-annually. This had successfully reduced the number of patients with poorly controlled diabetes by 50% which was a significant achievement in patient awareness, through education on self-care and regular face to face appointments at the patient's home or in the practice.
- The clinical commissioning group (CCG) medicines management team had visited the practice in June 2016 and requested eight standard audits of the practice on such areas as prescriptions, renal function testing, and different kinds of medicines used to treat conditions like asthma, high blood pressure, depression, and pain relief. The practice had carried out these eight audits within the same week. The findings of these audits had identified key actions which the practice was in the process of implementing. These audits were planned to be repeated twice a year.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice directly employed an innovative integrated nursing team (INT). The traditional practice nurse role and community nurse role was provided by the INT, who worked as practice nurses and also as community nurses, carrying out home visits across this large rural area with high numbers of older patients with complex conditions. The INT provided a wide range of nursing services seven days a week, 365 days a year from 8:30am to 5.30pm.
- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. The practice had a staff handbook both in paper and electronic format which had been reviewed in June 2016.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The practice had completed a fire drill evacuation in May 2016.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way. For example, the practice shared patient information in their multi-agency risk management (MARM) meetings with a range of other professional bodies to ensure the best possible patient outcomes. Information was shared in line with the Data Protection Act 1998.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- The practice had partially funded a local gym in Blandford Forum, in order for patients to access exercise easily at a reduced cost, before a new provider had stepped in to run the gym on a long term basis.
- The practice signposted patients to Live Well Dorset which was a healthy lifestyle advisory service providing advice on smoking cessation, weight management, drinking less and moving more.

The practice's uptake for the cervical screening programme was 81%, which was comparable with the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccinations given were comparable to the clinical commissioning group (CCG) and national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 95% to 100% and five year olds from 94% to 100% (CCG averages ranged between 93% to 97% and 92% to 97%).

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect. There were numerous examples of this at the practice;

- The practice undertook care planning to support hospital admission avoidance including palliative and end of life care, advanced care planning and having a focus on the patients preferred place of death. The practice team offered bereavement support to families as part of their end of life care. The practice focused on facilitating patients' preferred place of death. Between April 2015 to March 2016, of the 17 patients receiving end of life care from the practice, 70% achieved their preferred place of death, of which 65% died at home. The national average was 33%.
- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs. Patients who wished to speak in private at reception were taken into a private room.

All of the 98 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for the majority of its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 94% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 86% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the 98 comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were better than local and national averages. For example:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 96% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 90% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%

The practice provided facilities to help patients be involved in decisions about their care:

Outstanding ☆

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The practice was working towards the Accessible Information Standard which helped patients to access the service. The AIS was created by NHS England and states that by July 2016 patients who have a disability, impairment or sensory loss get information that they can access and any communication support that they need. The practice had portable hearing aid induction loop, braille on door signs and appropriate notes on patient records to highlight these needs to practice staff. Notes had been made on patient records to record any special needs such as hearing or vision problems to enable the practice to communicate with patients.
- There was a portable hearing aid induction loop at reception for patients who were hard of hearing.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice employed a dedicated carer's lead who provided support specifically to carer's registered with the practice. They had identified 4% of the practice population as being carers, which was significantly higher than the national average of 2%. They regularly updated the carer's register and the carer's noticeboard and provided advice to carer's and signposted them to relevant services. The practice also had a carer's support group with social events. Carers could make appointments with the carer's lead for advice; receive home visits, and joint visits with GPs. The carer's lead had written to all carer's, introducing themselves and identifying support, dementia bracelet (ID number help to identify them and enable others to return them safely home if required).

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

The practice had systems in place to identify military veterans and ensure their priority access to secondary care in line with the national Armed Forces Covenant. The practice military veteran's policy had been reviewed in May 2016. One of the practice GPs was a military veteran and had a good understanding of the issues involved.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice participated in the Vanguard Project which involved closer collaborative working with other healthcare providers; South Western Ambulance Service NHS Foundation Trust (SWAST), local hospitals, social care and other GP practices. The Vanguard Project is a government funded project to promote joined up working amongst practices. The practice had successfully bid for some of this funding to help to develop the role of the in reach nurse to go onto local hospital wards and support patients by setting up care packages including physiotherapy and occupational therapy, to help patients avoid the inconvenience of an extended stay in hospital.
- The practice directly employed a member of staff with and maintained a suitable vehicle for them to support local patients by delivering medicines to their homes in this rural area. They had received appropriate DBS (disclosure barring service) checks. The practice sub-contracted this service out to two other local practices to support their patients. The positive impact on around 60 patients in this rural area was that they had easy access to essential medicines.
- The practice had set up a voluntary patient transport service with 35 volunteer drivers which they called "neighbourcar". The positive impact on 190 patients in this rural area with poor public transport links was that they could see practice GPs or nurses face to face. This service also gave GPs nurses more time at the practice with other patients as it reduced the number of home visits required.
- The patient participation group (PPG) had suggested that the practice address the "did not attend" (DNA) rate more closely. The practice had responded to this by displaying the latest did not attend statistics in the waiting room and placed information on the impact of not attending a GP or nurse appointment in the local parish magazine.
- There were longer appointments available for patients with complex needs such as those with a diagnosis of depression, patients with multiple conditions or learning disabilities.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending this rural practice. A patient transport service was available with 35 volunteer drivers to support patients to access the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were facilities such as a toilet with disabled access, a portable hearing aid induction loop and telephone translation services available. GPs at the practice could speak other languages.
- The practice had level access and was based entirely on the ground floor.

Access to the service

The practice is open between the NHS contracted opening hours 8am - 6.30pm Monday to Friday. Appointments were offered anytime within these hours. Extended hours surgeries were offered on Saturday mornings from 8.30am to 10.30am. In addition, the practice integrated nursing team operated seven days a week from 8.30am to 6.30pm.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was better than local and national averages.

- 85% of patients were satisfied with the practice's opening hours compared to the national average of 75%.
- 94% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

Listening and learning from concerns and complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system. There was a poster on display and leaflets available in the waiting room which explained how to make a complaint should a patient wish to do so.

We looked at the one complaint received in the last 12 months and found that it had been satisfactorily handled and dealt with in a timely way. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

Are services well-led?

Outstanding ☆

(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 ethos to deliver high quality care and promote good outcomes for patients.

- The practice ethos, in summary, was to provide the highest standard of individualised healthcare in a safe, friendly and welcoming environment. This was displayed in the waiting areas and staff knew and understood the values.
- The practice had a robust strategy and supporting five year forward looking business plans which reflected the vision and values and were regularly monitored. This looked at collaboration and integration over the next five years.

The practice implemented their vision and values through sharing best practice with neighbouring practices, and piloting innovative schemes. GPs were open to new ideas and learning by sharing their own annual appraisal outcomes with each other and then using their shared resources to achieve these outcomes and deploying their expertise as a team.

The practice had also demonstrated adherence to its values through imaginative and successful responses to the needs of its patient population through the deployment of a successful carer's lead, initiating and organising rural medicine deliveries and rural patient transport services to support patients who would otherwise be significantly isolated from the practice.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure which included all members of staff, and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings. These included regular management team meetings. Partner meetings were held once a month. Dispensary meetings and reception meetings were held monthly. We saw that these were minuted meetings. An all staff meeting was held once a month. Clinical meetings were held twice a week.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held every six months.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Outstanding ☆

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

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. The PPG had suggested that the practice addressed the "did not attend" (DNA) rate more closely and notified patients of the impact. The practice had responded to this by displaying the latest did not attend statistics in the waiting room and placed information on the impact of not attending a GP or nurse appointment in the local parish magazine. We saw displayed on a noticeboard in the waiting room that in May 2016, 19 patients did not attend booked appointments with their GP and 32 did not attend booked appointments with a nurse, 3 did not attend booked appointments with the physiotherapist. Patients were informed that this equated to 10.5 hours of clinicians time which could have been deployed to support patients in greater need. Patient suggestions raised that extra support was sometimes needed for patients to complete written forms had been implemented. The practice had introduced a form which allowed patient's carers to support and to indicate that they had completed the form with the patient.
- A notice board informed patients of feedback the practice had received and action taken as a result of the feedback. For example, the practice had written that they appreciated the need for more phlebotomy appointments and had added more clinics to take blood samples to achieve this.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues. For example, staff had suggested having a carer's notice board on display in the waiting area. The practice had implemented this. Other suggestions which had been acted upon included more frequent dispensary team meetings, new uniforms for dispensary staff, and more recycling bins at the practice. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the numerous pilot schemes detailed within this report.

The practice employed a data analyst who carried out regular audits and provided advice on how to shape reporting and auditing for the practice and on a wider basis across the clinical commissioning group (CCG). The impact upon patients was that accurate and timely data analysis allowed prompt improvements to their care and treatment, for example in analysing medicine audits.

The practice was a teaching and a training practice, two of the practice GPs were qualified trainers. There was a GP registrar at the practice and a medical student present during our inspection. The practice also had two medical students visit the practice for training for a period of several weeks every year.