The Apples Medical Centre

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.

Summary of findings

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Overall summary

The Apples Medical Centre, East Mill Lane, Sherborne, Dorset, DT9 3DG provides primary medical services to people living in Sherborne, Dorset and the surrounding areas. The practice had no branch surgeries. The service provider was registered with CQC to provide the following regulated activities; Diagnostic and screening procedures, Family Planning, Maternity and midwifery services, Surgical Procedures and Treatment of disease, disorder or injury. There was a small dispensary which catered for patients who needed medication, appliances and dressings who lived more than one mile from their nearest pharmacy. At the time of our inspection there were approximately 5163 patients registered at the service with a team of 4 GPs. In addition there were nurse practitioners, nurses, and health care assistants. People who used the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors and midwives.

Patients spoke very positively about the staff employed at the practice and the level of care they received. Patients told us they felt that the practice was safe. They told us that care was given to them in accordance with their wishes and opportunities were given for informed decision making. Patients told us they felt the practice was responsive to their needs. For example, patients said that an urgent appointment could always be obtained on the day they contacted the practice and they could usually see their named GP for non-urgent visits. This was reflective of the information provided on the practice website and within the practice welcome pack.

Patients told us about their experiences of the practice. All of the responses from patients we spoke to on the day, from the 26 comment cards left for us and within the practice's own patient survey 2012/13 were very positive.

There was evidence that learning from incidents, significant events and investigations took place and appropriate changes were implemented to improve the practice and patient experiences.

As part of our inspection we took a GP as part of our team. They evidenced that the practice was effective in the way it provided care to people. In addition to the evidence obtained by our inspection team, the supporting data and documentation we reviewed about the practice demonstrated the practice performed very well when compared with all other practices within the Dorset Clinical Commissioning Group (CCG) area.

We saw the practice was well led, with a clear leadership structure in operation. The staff we spoke with spoke highly of the management within the practice and told us they felt supported in their roles. Supporting information reviewed during our inspection demonstrated the practice had appropriate systems in place that regularly monitored the safety and effectiveness of the care provided.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall we found the service was safe. Patients we spoke with told us they felt safe and felt very confident when being cared for by the clinical staff at the practice; whose opinions they trusted.

The practice had systems to help ensure patient safety.

Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent.

There was a system in operation that encouraged and supported staff to learn from any significant events or incidents. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

The practice had risk assessments and systems that minimised potential risks to the health, safety and welfare of the patients, staff and visitors that used the practice. There were suitable arrangements for the management of medicines.

The practice was observed to be clean. We found that suitable arrangements were in place that ensured the cleanliness of the practice was to a high standard and there were effective systems in place for the retention and disposal of clinical waste.

Are services effective?

Overall we found the service was effective. Supporting data obtained both prior to and during the inspection showed the practice had effective services.

The provider had a clinical audit system in process and audits had been completed. We saw that care and treatment was delivered in line with national best practice guidance.

The provider worked closely with other services to achieve the best outcome for patients who used the practice.

Staff employed at the practice received appropriate training, support and appraisal. GP partner's appraisals had been completed annually.

We saw that the practice had extensive health promotion material available within the practice and on the practice website.

Are services caring?

Overall we found the service was caring. We spoke with patients who spoke positively of the care provided at the practice. This was

Summary of findings

reflected in the practice annual survey as part of the provider's quality assurance system. Patients all told us how well the staff communicated with them, either about their health, health education or what was happening at the practice.

Patients told us they felt they had sufficient time to speak with their GP or a nurse. They said they felt well supported both during and after consultations, or through any subsequent diagnosis and treatment.

The provider told us patients who required urgent appointments were seen on the day and patients we spoke with told us they would be seen if required.

Are services responsive to people's needs?

Overall we found the service met people's needs. There was a virtual patient group that communicated electronically and some patients were keen to set up face to face meetings which were in progress with the practice manager's support. Patients all commented on how well all the staff communicated and praised their caring, professional attitude.

We saw there was a clear complaints policy available within the service and on the provider's website. The provider had responded appropriately and in a timely way to any complaints received. All the patients we spoke to said they had had no reason to complain and this was also reflected in the comment card responses we received.

The provider actively sought patient's views and gathered this information by ensuring that feedback forms were openly available within the practice. Patients were also encouraged to use the National Health Service website (NHS Choices). The provider's active approach to gaining feedback was apparent by the amount of comment cards received in our comments box in the period leading up to our inspection.

Patients told us they felt they had sufficient access to the practice and appointments could be made when they were needed and that the practice "went above and beyond" to help people.

Are services well-led?

Overall we found the service was well led. There was a clear leadership structure in operation. Both clinical and non-clinical staff demonstrated they were clear about their responsibilities and how and to whom they should escalate any concerns.

Staff spoke positively about their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open culture and "A great place to work".

Summary of findings

There was a clinical auditing system in operation with risk management tools being used to minimise any risks to patients, staff and visitors. There was an appropriate clinical governance system operated by the provider that ensured lessons were learned from events.

Summary of findings

The six population groups and what we found

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

Older people
Overall, we found the practice provided routine care and reviews to older patients.

The practice offered blood pressure monitoring and general well man/woman consultations. Appropriate systems ensured flu vaccination programmes were completed. Effective treatments and ongoing support for those patients identified with the early signs of dementia were available and the practice had undertaken additional training to ensure that current guidelines and evidence based practice was followed.

People with long-term conditions
Overall, we found the practice provided routine care to patients with long term health conditions.

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

We found patients with long term illnesses had their condition and medication reviewed when required. GPs also supported and trained patients to monitor their own conditions, especially older people with chronic conditions but also younger people.

Mothers, babies, children and young people
Overall, we found the practice provided routine care tomothers, babies and children.

Expectant mothers attended the practice and were seen for their initial antenatal assessment and then referred to the midwife.

The practice worked closely with community midwives and health visitors.

Appropriate systems were in place for the identification and referral of safeguarding matters that related to children and young people.

The practice worked with school nurses from a a local boarding school and held surgeries there twice a week to ensure good quality care which involved young people and their families/guardians.

The working-age population and those recently retired
Overall, we found the practice provided routine care to the working age population and recently retired patients.

Summary of findings

A telephone triage was available for patients at work and flexible appointment times were available throughout the week.

Suitable travel advice was available from the clinical staff within the practice and supporting information within the waiting areas.

People in vulnerable circumstances who may have poor access to primary care

Overall, we found the practice provided routine care to people in vulnerable circumstances.

People within vulnerable communities, for example the travelling community or the homeless were registered at the practice. Primary care was provided when required and liaison was sought with other professionals when required. Vaccinations were offered when required and managed safely. Appropriate arrangements were in place to ensure that people with mobility limitations had access to care.

People experiencing poor mental health

Overall, we found the practice offered routine care to people experiencing a mental health problem.

Routine care appointments for patients experiencing a mental health problem were available and advanced bookings could be made if required.

The practice evidenced they were responsive in making referrals for mental health concerns through patient feedback and records.

Liaison was undertaken with external agencies, for example the mental health crisis team, local support groups and counsellors when required.

We saw from supporting documentation that where people did not have the mental capacity to consent to a specific course of care or treatment, the provider had acted in accordance with the Mental Capacity Act 2005.

Summary of findings

What people who use the service say

We spoke with ten patients and 11 staff employed at the practice during our inspection and collected 26 patient responses from our comments box. We also spoke with representatives from the virtual Patient Participation Group (PPG) and a health visitor attached to the practice. The feedback from patients was very positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice.

Patients told us about their experiences of the service. On the day of our inspection patients told us directly "They listen to you, you can tell them anything", "The doctor is always there if I need him, I've been a patient all my life" and "They fit you in when they can and any referrals have been excellently managed".

Comments from our comment cards included "We have been looked after superbly and we respect their clinical advice", "I have always found the staff highly competent and professional" and "This practice is fantastic, I am delighted to be registered here". One patient said they had lived all over the world but could not find any issues to improve on at the practice.

Comments from the 2014 patient survey included "I think I receive outstanding health care and I have no complaints whatsoever", "Even though the practice is always busy the staff cope well and calmly. Whichever GP I see everything is explained clearly in layman's terms and my questions are always answered" and "I have always been more than happy with everyone I have spoken to/ seen at The Apples. Everyone is so helpful!"

The practice had provided patients with information about the regulatory function of the Care Quality Commission prior to the inspection and advertised our visit on their website and displayed our poster in the waiting room. Our comment box was displayed prominently and comment cards had been made available for patients to share their experience with us. We received a high number of comment card responses from patients and the practice had encouraged patients to feedback to us, anonymously if they wished. We also saw from the most recent annual patient survey for January 2014 that 200 surveys had been sent out by the practice with 181 responses received. This also showed many positive comments. Most of the patients we spoke to had been registered at the practice for many years or the practice had been recommended to them by a friend/ family member. We also spoke to four newly registered patients. Overall patients said that they felt listened to and could only think of minor issues that could be improved and they felt confident that the practice would be responsive to the patient "voice".

Areas for improvement

Action the service COULD take to improve

The providers complaints policy was not updated to include when and how to contact the Clinical Commissioning Group (CCG) and Ombudsman.

The provider did not pro-actively ensure that patients were aware that they are able to speak confidentially away from the reception area if they wished and a room was not allocated each practice day to avoid delays.

The providers staff policies did not inform staff about what steps to take in relation to patient restraint and violent behaviour to maintain patient and staff safety.

The provider had a chaperone policy but did had not ensured that all staff who acted as chaperones had had their training formalised so that they were clear about the role and responsibilities of a chaperone.

The provider did not have a consistent, robust system to audit and reconcile medication changes following discharge from another provider.

The provider had not ensured that all policies were regularly reviewed and updated and included review dates.

The practice nurse said information leaflets could be printed for patients on request in addition to those on display, although there was no full list available for patients to see.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

The provider were in the process of practice identifying those patients who acted as carers and developing formal support for them including tailored health checks. Once a month there was a Gold Standard Framework (GSF) meeting to discuss patients end of life care. This included the multidisciplinary team such as social workers, palliative care team, community matrons and the mental health team. The meeting primarily dealt with patients who had palliative care needs and other patients who had particular needs related to the GSF. The Practice Charter set out the practice and patient responsibilities so that patients knew what service to expect and how to help make it as effective as possible.

The Apples Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a second CQC inspector, a GP, a practice manager, a CQC pharmacist and an Expert by Experience.

Background to The Apples Medical Centre

The Apples Medical Centre provides primary medical services to people living in Sherborne, Dorset and the surrounding areas. The practice at East Mill Lane, Sherborne, Dorset, DT9 3DG had no branch surgeries. There was a small dispensary which caters for patients needing medication, appliances and dressings who lived more than one mile from their nearest pharmacy. At the time of our inspection there were approximately 5163 patients registered at the service with a team of 4 GPs meeting patients' needs. In addition there were nurse practitioners, nurses, and health care assistants. People who used the practice also had access to community staff including district nurses, community psychiatric nurses, health visitors and midwives.

The practice provided services to a diverse population age group. The practice employed a practice manager, two practice nurses, a healthcare assistant, a secretary, dispensary staff, an information technology administrator and six receptionists.

The practice reception was open between 08.00am until 6.30pm Monday to Friday except on bank holidays. Routine appointments were available daily and urgent appointments were made available on the day of the patient's request. The practice also offered later appointments for patients from 6.30-7.10pm on Monday and Tuesday evenings. Once a month there was a Saturday practice from 08.30-11.10am.

Why we carried out this inspection

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

How we carried out this inspection

Before conducting our announced inspection of The Apples Medical Centre, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England and Clinical Commissioning Group We requested information and documentation from the provider which was made available to us either before or during the inspection.

We carried out our announced visit on 2 June 2014. We spoke with ten patients and 11 staff employed at the practice during our inspection and collected 26 patient responses from our comments box which had been displayed in the waiting room. We obtained information and support and spoke with the practice manager, two general practitioners (GPs) part-time and full time, receptionists/summarisers, the dispensary supervisor and dispensary staff and practice nurses, a health care assistant and an ICT administrator. We observed how the practice was run and looked at the facilities and the information

available to patients. We also spoke with representatives from the virtual patient participation group (PPG) and a health visitor attached to the practice. We looked at documentation that related to the management of The Apples Medical Centre and patient records during our inspection. We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)
- People with long term conditions
- Mothers, children and young people
- Working age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problem.

Are services safe?

Summary of findings

Overall we found the service was safe. Patients we spoke with told us they felt safe and felt very confident when being cared for by the clinical staff at the practice whose opinions they trusted.

The practice had systems to help ensure patient safety.

Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent.

There was a system in operation that encouraged and supported staff to learn from any significant events or incidents. There were suitable safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

The practice had risk assessments and systems that minimised potential risks to the health safety and welfare of the patients, staff and visitors that used the practice. There were suitable arrangements for the management of medicines.

The practice was observed to be clean. We found that suitable arrangements were in place that ensured the cleanliness of the practice was to a high standard and there were effective systems in place for the retention and disposal of clinical waste.

Our findings

Safe Patient Care

Staff were aware of the significant event reporting process and how they would escalate concerns within the practice. There was a communication book for all staff to use when initially sharing information and issues would then be included on a meeting agenda. All staff we spoke with felt very able to raise any concern however small with the team as a whole. For example, identifying the need for adapted IT equipment for a staff member. Staff also demonstrated knowledge that following a significant event, the practice would undertake a Significant Event Analysis (SEA) to establish the full details of the incident and the full circumstances surrounding it.

Learning from Incidents

We looked at the significant event reporting process and SEA documentation. The practice used a standard document for all significant event reports. The practice manager told us the clinicians discussed these significant events when they were identified, but also formally at regular meetings. The GPs told us significant events were recorded formally and discussed in weekly clinical staff meetings as part of the ongoing agenda. We saw the form included action plans and root cause analysis (a method of problem solving that tries to identify the root causes of faults or problems) to ensure that there was learning from these events. Subjects in the past had included cancer deaths.

We looked at two examples and saw these had been discussed, learning noted and there were action plans. We followed one issue up and saw the action stated had been done and that all staff were aware of the issue. We looked at one event where it had been noted through checking fridge temperatures that there was a possibility the correct temperature for vaccines had not been maintained. There was a clear audit trail and comprehensive folder detailing the actions which had been taken. This included gaining specialist health professional advice, communicating with patients and ensuring that future risks were minimised. This showed the provider demonstrated transparency in identifying and recording significant events and ensured that matters were investigated with learning outcomes identified and shared with the staff team.

Are services safe?

Safeguarding

There was a GP partner with a lead role for both older people and young people safeguarding. We saw they had been trained to the appropriate level (level 3). There were appropriate policies in place to direct staff on when and how to make a safeguarding referral and details were displayed where staff could easily find them. The policies included information on external agency contacts, for example the local safeguarding team. There were three monthly safeguarding meetings with relevant attached health professionals. We spoke to the health visitor who told us these were very helpful so that all parties were aware of risk areas. For example, if a child looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up. The computer based patient record system allowed information relevant to safeguarding to be flagged up and alert staff to areas of risk. During the inspection an information link to relevant family members was also added. This ensured that in the event the vulnerable adult or at risk child was seen by different clinicians, all would be aware of their circumstances and this important information would not be lost.

We were given examples of current safeguarding risks. When we looked at records these showed the correct details which ensured that staff were alerted on each visit. For example, children at risk, family circumstances and vulnerable older people. The practice were developing the system to also flag up carers; who may need support or have particular needs. The staff we spoke with told us they had received safeguarding training which training records confirmed. They told us they were aware of who the safeguarding leads were and demonstrated knowledge of how to make a referral or escalate a safeguarding concern internally. As a small practice it was clear that all staff were aware of risk areas and patients' needs were well known. The health visitor said that it was rare that either party would not know about the same patients at risk as there was good communication which was further helped by the new computer system.

Monitoring Safety & Responding to Risk

We saw the practice had a number of risk assessments in place which ensured the health and safety of patients, visitors and staff members. These included risk assessments related to fire hazards and health and safety. The provider had a suitable business continuity plan that documented the surgeries response to any prolonged period of events that may compromise patient safety. For example, this included computer loss and lists of essential equipment.

The provider evidenced that future risks or impacts to the service were identified at the earliest opportunity. For example, we saw that the practice had identified that there was a longer wait for nurse appointments and this had been discussed and a new phlebotomist employed to help reduce the waiting time for patients. One GP was retiring and patients had been informed well in advance so they were aware of changes.

Medicines Management

There was a small dispensary which catered for patients needing medication, appliances and dressings who lived more than one mile from their nearest pharmacy. We discussed the systems in place for prescribing medicines and looked at the procedures for authorising repeat prescriptions. We saw there were systems in place which ensured that all prescriptions were authorised by the prescriber. The computer system highlighted high risk medicines, and those requiring more detailed monitoring. We discussed the way patients' records were updated following a hospital discharge and saw that systems were in place to make sure any changes that were made to people's medicines were authorised by the prescriber.

We saw that medicines and prescription pads were stored safely and there were appropriate arrangements for controlled drugs and those medicines requiring cold storage. There were systems in place so that checks took place to ensure products were within their expiry dates. There were standard operating procedures (SOPs) in place for the dispensing of medicines. We saw that all medicines dispensed from the practice were dispensed and checked by trained staff. There were systems in place to make sure any medicines alerts or recalls were actioned by staff. There were systems to record any incidents occurring (or 'near misses') so that lessons could be learnt and procedures changed if necessary to reduce the risks in future.

Cleanliness & Infection Control

Patients we spoke to said the practice was always very clean. The cleaner and maintenance person both lived in the flat underneath the practice and maintained a high quality service. The provider had an infection control policy and a dedicated infection control lead who attended up to date training. We saw records that they cascaded

Are services safe?

information to the staff team who also undertook additional training. Meeting minutes showed that infection control was included in meeting agendas and any identified issues discussed. The treatment and consulting rooms appeared very clean, tidy and uncluttered. We saw that staff all knew where items were kept and worked in a clean environment. The clinical rooms were stocked with personal protective equipment (PPE) which included a range of disposable gloves, aprons and coverings, which we saw staff had used. This reduced the risk of cross infection between patients. We saw antibacterial gel was available in the reception area for people to use upon entering the practice. We saw within communal areas, for example the public toilets, antibacterial hand wash and paper towels were available.

We saw there was an appropriate system for safely handling, storing and disposing of clinical waste. Clinical waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company. There were cleaning schedules in place and an infection control audit system was in operation. Treatment rooms had hard flooring to simplify the clearance of spillages. The staff training record showed that most staff had received updated training in infection control.

Staffing & Recruitment

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. We looked at the recruitment files of four staff most recently employed at the practice. We found the provider had ensured that most of required checks required for staff had been completed or they were in the process of being completed at the time of our inspection. We found that where required, Disclosure and Barring Service (DBS) checks had been completed. The DBS check ensured that any person previously barred from working with vulnerable groups was identified. We found that references had been obtained for staff and for clinical staff a check Nursing and Midwifery Council (NMC) status was completed and checked annually. Some application forms for staff employed before the practice was registered demonstrated minor periods of a break in the staff members employment history that had not been explored as required. Also although verbal references for staff had been obtained, these had not always been recorded by the GP. The practice manager said that this would now be completed.

Dealing with Emergencies

There was a duty system in operation that ensured one of the nominated GP partners could respond to emergency situations, for example emergency home visits. Within the practice, the provider had ensured that appropriate equipment was available to deal with an emergency, for example if a patient collapsed, which had once occurred in the car park. Staff had been able to easily locate the equipment, which was in a “grab bag” where all staff could reach it and kept safely. We saw that an Automated External Defibrillator was held within the practice; together with emergency drugs for other possible emergencies and that all staff were trained in emergency first aid. During the inspection we saw how calmly and efficiently staff worked as a team to assist a patient who felt increasingly unwell in the waiting room.

Equipment

We looked at the emergency medicines and equipment available, together with the arrangements in place that ensured the equipment and medicines were serviced or safe to use. We saw that equipment such as the weighing scales; blood pressure monitors and the electrocardiogram (ECG) machine were serviced and calibrated where required.

We saw that emergency medicines available to the practice were within their expiry date. The provider had an effective system using standard checklists that monitored the dates of emergency medicines and other items which ensured they were discarded and replaced as required.

Are services effective?

(for example, treatment is effective)

Summary of findings

The provider met all of the standards and overall we found the service was effective. Supporting data obtained both prior to and during the inspection showed the practice was effective.

The provider had a clinical audit system in process and audits had been completed. We saw that care and treatment was delivered in line with national best practice guidance.

The provider worked closely with other services to achieve the best outcome for patients who used the practice.

Staff employed at the practice received appropriate training, support and appraisal. GP partner's appraisals had been completed annually.

We saw that the practice had extensive health promotion material available within the practice and on the practice website.

Our findings

Promoting Best Practice

We saw several examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Clinical Excellence (NICE) guidance and we saw that where required, guidance from the Mental Capacity Act 2005 had been followed.

The practice used the quality outcome framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The QOF data for this practice showed that it generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local Clinical Commissioning Group (CCG) data demonstrated that the practice performed well in comparison to other surgeries and practices within the CCG.

Management, monitoring and improving outcomes for people

The practice was keen to ensure that staff had the skills to meet patient's needs. For example, due to a growing older people population the practice had ensured all staff had undertaken training in dementia care including diagnosis and its care implications. Patients were offered assessments and referred to the local memory clinic if appropriate and given an ongoing advanced care plan. There was also an annual check and health action plan for patients living with learning difficulties. The practice also worked closely with a local boarding school with a named GP attending two practice sessions there a week. They were setting up more formal support for the school nurses, for example to assist with their supervision and appraisal requirements and assisted with issues such as continence promotion and treatments. The nature of these patients required that there was direct communication with not only the house matron but with parents who may live abroad which the practice managed well. The practice were also focussing on identifying patients who were also carers so they could offer specialist support and advice.

Staffing

All of the clinicians in the practice participated in the appraisal system leading to revalidation over a five-year

Are services effective?

(for example, treatment is effective)

cycle. We saw these appraisals have been appropriately completed. We spoke with other clinical staff, for example the senior practice nurse, and non-clinical staff about appraisal. All told us they received appraisal and we saw documented evidence to confirm this was robust. We saw a comprehensive induction process for new staff. We spoke to the new staff member who commented that since they had been working at the practice they had seen such a positive "can do" attitude from everyone. All staff felt well supported.

We saw the staff training record supplied to us by the practice manager. This showed that all staff were up to date with mandatory training and had attended training such as infection control, confidentiality, and customer care and data protection. Staff said that they could ask to attend any relevant external training to further their development such as National Vocational Qualifications (NVQ) and ear syringing.

Working with other services

Once a month there was a Gold Standard Framework (GSF) meeting to discuss patients end of life care. This included the multidisciplinary team such as social workers, palliative care team, community matrons and the mental health team. The meeting primarily dealt with patients who had palliative care needs and other patients who had particular needs related to the GSF. We saw that comments received from a relative had been taken seriously and a meeting had been arranged to discuss the issues and look as to how improvements in the service could be made.

Health Promotion & Prevention

New patients with a higher level of disorders or diseases on the screening assessment or patients with an identified higher level alcohol or smoking risk were reviewed in the practice by the practice nurse or GP if required. Well women and man clinics and vaccination clinics were also offered. This enabled the clinicians to recommend lifestyle changes to patients and promote health improvements which might reduce dependency on healthcare services.

The Practice Charter set out the practice and patient responsibilities so that patients knew what service to expect and how to help make it as effective as possible. We were told by GPs they also supported and trained patients to monitor their own conditions, especially those older people or younger people with chronic conditions. This included information sharing and lending blood pressure monitoring equipment for instance. This showed that the practice worked in partnership with patients.

There were a range of leaflets and information documents available for patients within the practice and on the computer database. We saw that within the practice, leaflets were available for mental health issues, smoking cessation, support groups such as domestic violence support, diet and how to live a healthy lifestyle. The practice website had links for patients to follow which included how to obtain urgent medical advice and support, healthy lifestyle, holiday health and self-treatment of common illness and accidents. These links were on the home page of the providers website and very simple to locate.

Are services caring?

Summary of findings

The provider met all of the standards and overall we found the service was caring. We spoke with patients who spoke positively of the care provided at the practice and this was reflected in the practice annual survey as part of the provider's quality assurance system. Patients all told us how well the staff communicated with them, either about their health, health education and what was happening at the practice.

Patients told us they felt they had sufficient time to speak with their GP or a nurse and said they felt well supported both during and after consultations, or through any subsequent diagnosis and treatment.

The provider told us that patients who required urgent appointments were seen on the day and patients we spoke with told us they would be seen if required.

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by both clinical and non-clinical staff. Every patient we spoke with and each comment card praised the way staff went above and beyond to help them. They told us that staff were excellent, patient and were good listeners and they never felt rushed during appointments. Patients said they felt lucky to have such a good facility.

We saw that patient confidentiality was respected within the practice. The waiting area had sufficient seating and was located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. The provider could further pro-actively ensure that patients were aware that they were able to speak confidentially away from the reception area if they wished. This could be achieved by making sure a room was allocated each practice day for this purpose rather than staff having to find out which areas were free as there was no permanent private room. However, we made numerous observations throughout the day of reception staff communicating pleasantly and respectfully with patients. We saw how one patient was assisted to a free private room as staff recognised they looked unwell. Patients told us they found reception staff particularly accommodating, polite and friendly and they liked the way that each GP personally came to the waiting room to collect them for their appointment.

The incoming telephone lines to the practice were located in the area behind the reception desk which was behind glass screens, so no conversations between the reception staff and patients were audible in the waiting room. The practice did not have a hearing aid loop system but were looking into ways to ensure that those with limited hearing were able to converse more privately if necessary.

We made observations and patients told us they felt all conversations with clinical staff were confidential and told us conversations were always conducted behind a closed door. Within consultation and treatment rooms, we saw windows were obscured with blinds or curtains to ensure people's privacy. Consultation rooms were along a staff only corridor. The GP partner's consultation rooms were also fitted with dignity curtains to maintain privacy.

Are services caring?

We discussed with staff the use of chaperones to support people when examinations or consultations were carried out. The practice had a system for providing chaperone support for patients ensuring when patients registered with the practice if they had any requirements for a chaperone this was recorded in their records. Notices informed patients that a chaperone was available, for example during intimate examinations. This meant staff were made of aware of need to make a chaperone available to provide assistance when people visited the practice. Usually the nurses took on the chaperone role and when they were not available reception staff were also used. Although it was clear that staff knew that the role of the chaperone was to support and be an advocate for the patient; the provider may wish to note that there was no formal chaperone training to ensure consistent knowledge and practice. We also discussed ways of differentiating between the role of the receptionist and chaperone. The practice had a written policy and guidance for providing a chaperone for people which included expectations of how staff were to provide assistance. This meant there were appropriate systems in place to respect and maintain people's privacy and dignity.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they have sufficient time to discuss their concerns with their GP. The website and information leaflet informed patients that the practice ran ten minute appointment slots and for patients to let the practice know if they felt they needed a double appointment. The patient survey had included discussion about offering patients 15 minute slots and this was now in place; which patients told us they found useful. Patients said that different treatment options were discussed with them, together with the positive and possible negative effects the treatment may have. Patients said that where required, their GP or the practice nurse would give them information on their condition and treatment options. The practice nurse said information leaflets could be printed for patients on request in addition to those on display. The provider may like to note; a list of those available may be helpful for patients and leaflets about more sensitive issues could be made available in the rest rooms.

Patients told us that nothing was undertaken without their agreement or consent within the practice. The practice manager told us that they had less than 1% of their demographic whose first language was not English; that they knew those patients well and they understood English. The practice knew how to access language interpretation services if information was not understood enough by the patient to make an informed decision or to obtain consent to treatment. Family members, such as children, were not used to assist with interpretation unless a wife or husband for example were happy to share information in that way. We saw from supporting documentation that where people did not have the mental capacity to consent to a specific course of care or treatment, the provider had acted in accordance with the Mental Capacity Act 2005. Alerts on patient records also flagged up important information to inform staff as to which family member they were able to share information with.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The provider met all of the standards and overall we found the service met people's needs. There was a virtual patient group that communicated electronically and some patients were keen to set up face to face meetings which were in progress with the practice manager's support. Patients all commented on how well all the staff communicated and praised their caring, professional attitude.

We saw there was a clear complaints policy that was available within the service and on the provider's website. The provider had responded appropriately and timely to any complaints received. All the patients we spoke to said they had had no reason to complain and this was also reflected in the comment card responses.

The provider actively promoted feedback to listen to people's views by ensuring that feedback forms were openly available within the practice and people were encouraged to use the National Health Service website (NHS Choices). This was apparent by the amount of comment cards received in our box.

Patients told us they felt they had sufficient access to the practice and appointments could be made when they were needed and that the practice "went above and beyond" to help people.

Our findings

Responding to and meeting people's needs

The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users, undercover outside space to store pushchairs and additional seating or people who had difficulty sitting or reduced mobility. The reception staff were pleasant and respectful towards the patients.

Patients we spoke with told us they felt the practice were responsive to their individual needs. They told us that appointment times were available to suit them. Patients said that they had been visited at home when appropriate and they felt confident the service would meet their needs. GPs told us home visits were allocated in relation to GPs personal lists if possible. We asked people how the practice responded to any complaints or concerns they had. People we spoke with told us they had not made any complaints nor did they have any concerns, however they felt confident they would be listened to. We saw from the provider's complaint responses that complaints were responded to in an appropriate and timely manner.

We saw the practice responded to changing patient needs. For example, the health care assistant said that it had been difficult to accommodate all the requests for routine health checks so a phlebotomist (someone who is specially trained to take blood samples as their main role) was being added to the team to hold clinics for blood tests. This meant patients could be seen by the nurse more quickly.

We looked at the system for making referrals to secondary health care. We saw from records these were well documented with enough detail and monitored to ensure the correct referrals were made in a timely way. "Tasks" (part of the computer system which allows written tasks to be sent to named people on the same system) were up to date and the administrator was clearly knowledgeable about the patients. 80% of referrals were to Yeovil Hospital and 20% to Dorchester depending on the speciality and patient need. We saw that one patient had been able to make an appointment in their home town so they could be supported by their parent, which showed the practice was responsive to patients' needs. Patients we spoke with told us that any referral to secondary care had always been discussed with them and actioned in a timely way.

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a virtual patient group that communicated by email. We spoke with patient group representatives about the provider's engagement and responsiveness. They spoke highly of the interaction with the GP partners at the practice and stated some members were keen to develop regular face to face meetings. We saw that the patient group had been consulted prior to the last annual patient survey and their views taken into account, for example about what topics would be effective for the survey.

Access to the service

The GP's provided a personal patient list system. These lists were covered by colleagues when GPs were absent. Patients were able to telephone the practice between 09.30-10.00am if they wished to speak to a GP and at other times told when would be a good time to call back or to speak to the duty GP. GPs told us that usually patients with urgent needs could be seen the same day. We saw that for non urgent appointments patients were seen within a week. Patients told us that if they required an urgent appointment they would always be seen on the day they requested an appointment. A patient during the inspection told us they had contacted the practice on that day and had obtained an appointment shortly after.

The appointment system at the practice had factored in space which allowed for when appointments over-ran. Patients told us that sometimes they had to wait but they knew that they would be listened to and not rushed. Most patients commented that the practice went out of their way to accommodate them, usually with the GP they preferred. Patients could book appointments by telephoning the practice, attending the practice in person or using the on-line booking service for future appointments. The provider's website gave detailed information on the appointment system within the practice and when specific times were designed to meet people's needs. The practice also had two late clinics to assist the working population in accessing their GP and a once a month Saturday morning clinic.

In addition to the provider's website, a practice information welcome leaflet for patients was available in the reception area and contained appropriate information on the services provided by the practice. It contained information on staff employed at the practice, opening times, appointments, home visits, out of hours care and telephone call back services. Patients told us that appointments were easy to get, with the GP they wanted and that communication with the practice was very good.

Concerns & Complaints

We saw that the provider had an effective complaints procedure in place. The practice manager said their door was always open for patients to discuss any concerns. They followed the practice complaints policy and ensured that they ascertained what the patient's expectations were and what outcome they were seeking. There had been no recent complaints and each patient and comment card stated that patients rarely had the need to complain as they could discuss any issues then and there.

Information on how to raise a complaint or concern was displayed within the practice and information was also available on the provider's website. The practice complaint information for patients described how people should raise their complaint in the first instance; the formal process that would then be undertaken following the submission of the complaint and the timescales in which the practice would respond. The complaints leaflet also gave appropriate information of other regulatory bodies to whom patients could complaint. The information was not up to date and needed reviewing.

Are services well-led?

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

Summary of findings

The provider met all of the standards and overall we found the service was well led. There was a clear leadership structure in operation. Both clinical and non-clinical staff demonstrated they were clear about their responsibilities and how and to whom they should escalate any concerns.

Staff spoke positively about their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open culture and "A great place to work".

There was a clinical auditing system in operation with risk management tools being used to minimise any risks to patients, staff and visitors. There was an appropriate clinical governance system operated by the provider that ensured lessons were learned from events.

Our findings

Leadership & Culture

We spoke with clinical and non-clinical staff during the inspection process. All spoke highly of their employment at the practice and the standard of leadership they worked under. All said that the GP partners were very approachable and said there was a strong team ethos throughout the practice. This was evident in the way that all team members were encouraged to communicate through the communication book; during meetings; preparing the agenda and through staff supervision and appraisal. All of the staff we spoke with made very positive references to the open culture within the practice.

Governance Arrangements

We found there were suitable systems in operation to manage governance of the practice. The GPs told us they looked at the practice visions and values and met quarterly to; look at the bigger picture; such as to set practice goals and plans that met patients needs. The practice had structured meetings that ensured information was shared. For example, a business meeting was held weekly that involved the GP partners, the practice manager and the practice nurse. Clinical issues and matters related to the running of the practice such as staffing were discussed. This ensured that matters that may have an impact on patient care and safety were discussed to ensure awareness and effective service delivery.

There were weekly practice nurse meetings when all the nurses were available to catch up, share information, training and feedback. For all meetings minutes were displayed in the conference room for staff to sign that they had read them. This ensured that all staff, full and part-time were up to date. Monthly staff meeting minutes were comprehensive and covered a wide range of topics. There were also separate receptionist/summarisers meetings where suggestions for improved ways of working were discussed. For example, tasks were changed so that urgent referrals were put on separate dictaphone tapes so they had priority. The minutes also recorded that where an action was agreed to be completed by a staff member by a specific date, this was recorded on the minutes. This helped monitor the completion of actions important to the practice.

We also saw that other meetings specific to various functions of the practice were held. For example, there was

Are services well-led?

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

an infection control meeting which included the cleaner, quarterly health visitor meetings to discuss areas of risk and monthly safeguarding meetings where case studies could be discussed.

Systems to monitor and improve quality & improvement

The quality of care was reflected in the practice achievements against the Quality Outcomes Framework (QOF). There was a QOF lead in the practice and each clinician and practice nurses contributed to the practice achieving its current achievements.

The clinical auditing system assisted in driving improvement and the practice undertook additional auditing. An example of this was the practice had audited hand washing, infection control, complaints and significant events. Actions were then taken to drive improvement, for example following the infection control audit a steam cleaner had been bought to help provide a cleaner environment and improve infection control.

Patient Experience & Involvement

The practice recognised the importance of patient feedback and ensured that appropriate facilities were available and advertised for patients to see. In the reception area there were satisfaction surveys available. They sought the views of patients in relation to the time they had for an appointment; if patients felt listened to; if they received sufficient information and their overall patient satisfaction. We looked at a sample of the surveys that had been submitted to the practice. All showed very high levels of satisfaction which was mirrored during our conversations with patients and in our comment cards. There were no negative responses at all. In addition to their own internal system, the provider encouraged patients to submit feedback on the national NHS choices website. The practice manager was about to respond to these and would continue to do so. We studied this feedback as part of our pre-inspection planning. The general feedback on the website was very positive about the practice.

The provider and patient group also recorded patient experience in an annual survey. The questions in the latest survey completed January 2014 had been discussed with the patient group and then 200 surveys sent out over two weeks with 181 responses. These were very positive and an action plan had been devised based on findings and actions taken such as increasing appointments to 15 minutes, starting a quarterly practice newsletter and sourcing a self-service check in screen to free up reception time.

Learning & Improvement

Staff demonstrated awareness of the incident reporting policy. Any significant events or incidents had been recorded on the provider's standardised document. The significant event was discussed at or near the time it was reported, and also at quarterly meetings in the form of a Significant Event Analysis (SEA). The SEA meetings involved the GP partners and any staff appropriate to the matter to the significant event being analysed. This could include both clinical and non-clinical staff. Staff we spoke with told us the SEA meetings were valuable and that the learning from these meetings reduced the risk of the event or incident occurring again.

We saw from the Significant Event Analysis (SEA) meeting agendas that patient complaints were discussed with GP partners and staff to ensure learning had taken place from the complaint and where applicable the risk of repetition had been minimised. For example, all comments were taken seriously such as from a relative relating to end of life care and this had been dealt with and discussed in a sensitive way.

Identification & Management of Risk

We saw the provider had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. We saw risk assessments had been completed for health and safety risks relating to the building. In addition, a fire risk assessment had been completed and we saw that fire systems and equipment were subject to regular testing. An external company carried out regular fire audits of the premises and the practice had two named fire marshals. The practice was protected by a security alarm system and we saw this was also subject to periodic testing and servicing. The provider had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. This included, for example, if the electricity supply failed, IT was lost or if the telephone lines at the practice failed to work.

Older people

All people in the practice population who are aged 75 and over. This includes those who have good health and those who may have one or more long-term conditions, both physical and mental.

Summary of findings

Overall, we found the practice provided routine care and reviews to older patients.

The practice offered blood pressure monitoring and general well man/woman consultations.

Appropriate systems ensured flu vaccination programmes were completed. Effective treatments and ongoing support for those patients identified with the early signs of dementia were available and the practice had undertaken additional training to ensure that current guidelines and evidence based practice was followed.

Our findings

The surgery offered routine care to older patients. This included, for example, blood tests, blood pressure monitoring and general well man/woman consultations. The practice also supported patients to monitor their own conditions at home using blood pressure equipment for example. Patients told us that they were pleased to be supported to take responsibility for their own conditions that were long term for example..

We saw that the surgery had appropriate systems that ensured flu vaccinations were routinely offered to older patients which helped protect them against the virus and associated illness.

We found the practice to be caring in the support it offered to older patients and there were effective treatments and ongoing support for those patients identified with early signs of dementia. The surgery used a six point cognitive impairment test following any specific reported concerns from relatives, friends or where the patients GP suspected cognitive impairment and the practice had undertaken additional training to ensure that current guidelines and evidence based practice was followed.

People with long term conditions

People with long term conditions are those with on-going health problems that cannot be cured. These problems can be managed with medication and other therapies. Examples of long term conditions are diabetes, dementia, CVD, musculoskeletal conditions and COPD (this list is not exhaustive).

Summary of findings

Overall, we found the practice provided routine care to patients with long term health conditions.

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

We found patients with long term illnesses had their condition and medication reviewed when required. GPs also supported and trained patients to monitor their own conditions, especially older people with chronic conditions but also younger people.

Our findings

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Patients with long term illnesses had their condition reviewed when required. The practice completed regular medication reviews and patients we spoke with who had been on long term medication told us they felt their condition and medication was reviewed to their satisfaction. This meant that patients with long term conditions were appropriately monitored and medication could be monitored to ensure their wellbeing.

The practice had also begun to develop a register of patients who were also carers to support them and ensure that they continued to be able to provide a carers role.

Mothers, babies, children and young people

This group includes mothers, babies, children and young people. For mothers, this will include pre-natal care and advice. For children and young people we will use the legal definition of a child, which includes young people up to the age of 19 years old.

Summary of findings

Overall, we found the practice provided routine care to mothers, babies and children.

Expectant mothers attended the practice and were seen for their initial antenatal assessment and then referred to the midwife.

The practice worked closely with community midwives and health visitors.

Appropriate systems were in place for the identification and referral of safeguarding matters that related to children and young people.

The practice worked with school nurses from a a local boarding school and held surgeries there twice a week to ensure good quality care which involved young people and their families/guardians.

Our findings

Mothers, babies, children and young people received routine care from the practice. Expectant mothers attended the practice and were seen for their initial antenatal assessment and then referred to the midwife.

The practice worked closely with both the midwives and health visitors who were now able to communicate using the same computer system as the practice.

There was a GP partner who had a lead responsibility for child safeguarding. We saw they had been trained up to the appropriate level (level 3). We saw that appropriate safeguarding policies and referral guidance was available for staff. This ensured they had sufficient information make a child safeguarding referral if required. We saw from patient records that a child identified as at risk had an icon on their electronic patient record screen to advise the clinician of their status. This would ensure that in the event of a child identified as being at risk was seen by different clinicians; this important information would not be lost.

Working age people (and those recently retired)

This group includes people above the age of 19 and those up to the age of 74. We have included people aged between 16 and 19 in the children group, rather than in the working age category.

Summary of findings

Overall, we found the practice provided routine care to the working age population and recently retired patients.

A telephone triage was available for patients at work and flexible appointment times were available throughout the week.

Suitable travel advice was available from the clinical staff within the practice and supporting information within the waiting areas.

Our findings

The working age population and those recently retired were offered routine care by the practice. The practice offered a telephone triage service daily to provide a service to patients. This was in addition to patients attending for appointments. The surgery opened later on some days and on some weekends so that the needs were met for patients who could only attend after work.

We saw that flu vaccinations were offered to the working age population and those recently retired to help protect them against the virus and associated illness. The practice also offered travel vaccinations and travel advice. There was appropriate supporting information within the surgery for people travelling abroad and staff had had appropriate training.

People in vulnerable circumstances who may have poor access to primary care

There are a number of different groups of people included here. These are people who live in particular circumstances which make them vulnerable and may also make it harder for them to access primary care. This includes gypsies, travellers, homeless people, vulnerable migrants, sex workers, people with learning disabilities (this is not an exhaustive list).

Summary of findings

Overall, we found the practice provided routine care to people in vulnerable circumstances.

People within vulnerable communities were registered at the practice. Primary care was provided when required and liaison was sought with other professionals when required.

Vaccinations were offered when required and managed safely. Appropriate arrangements were in place to ensure that people with mobility limitations had access to care.

Our findings

The practice provided routine care to patients in vulnerable circumstances who may have poor or limited access to primary care. The liaised with other professionals such as the community nurse and health visitors to ensure matters such as child immunisations were completed for patients who were temporary residents or travellers for example.

Flu vaccinations were routinely offered to patients who were in vulnerable circumstances who may have poor access to a GP to help protect them against the virus and associated illness.

We found that the practice was caring about vulnerable patients who were not mobile or able to access the surgery with ease. There was information within the surgery and available on the practice website about home visits and how one could be arranged. Patients told us that they had appreciated this service.

People experiencing poor mental health

This group includes those across the spectrum of people experiencing poor mental health. This may range from depression including post natal depression to severe mental illnesses such as schizophrenia.

Summary of findings

Overall, we found the practice offered routine care to people experiencing a mental health problem.

Routine care appointments for patients experiencing a mental health problem were available and advanced bookings could be made if required.

The practice evidenced they were responsive in making referrals for mental health concerns through patient feedback and records.

Liaison was undertaken with external agencies, for example the mental health crisis team, local support groups and counsellors when required.

We saw from supporting documentation that where people did not have the mental capacity to consent to a specific course of care or treatment, the provider had acted in accordance with the Mental Capacity Act 2005.

Our findings

We saw that the practice offered routine care to patients experiencing a mental health problem. Patients were offered same day pre-booked and follow up appointments were available. If patients wanted to discuss matters in person with their own GP, appointments were available to book in advance.

The practice was responsive in referring patients to other service providers for ongoing support. The practice had ensured that information was made available for patients for external specialists, for example counselling or support groups.

The practice had a close liaison with the local mental health crisis team and attended multi agency meetings when required to discuss patient concerns. Staff were able to tell us about examples where patients had not had the capacity to consent and records we looked at showed that the provider had acted in accordance with the Mental Capacity Act 2005 to ensure that decisions were made in patients' best interests and following best practice guidelines.