Royal Manor Health Care

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Royal Manor Health Care on 24 June 2015. Overall the practice is rated as good.

Specifically we rated the practice as good for providing safe, effective, caring, responsive and well-led services. The practice was rated as good for providing services to the population groups of 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 and people experiencing poor mental health (including people with dementia).

The practice is the only registered location for the provider Portland Group Practice and the provider has a branch surgery at Gatehouse Surgery, Castle Road, Portland, Dorset, DT5 1 AU.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents. Action was taken in response to incidents and events and learning as a result of incidents and events was shared with staff.
- Risks to patients were assessed and managed and all staff had received training in how to conduct a risk assessment.
- Patients were treated with compassion, dignity and respect and supported to make decisions about their care.
- The practice responded to feedback from patients and from the Patient Participation Group.
- The practice had a clear leadership structure and staff were supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice used the Quality and Outcomes Framework to measure its performance and QOF data for 2013/2014 indicated that the practice had achieved 95.6% of the total points available.

Summary of findings

- We saw one area of outstanding practice: The practice provided a 'tea and chat' service for patients who were isolated. The sessions were used to provide health advice to patients on matters such as sun safety.

However, there were also areas of practice where the provider needs to make improvements.

The provider should:

- Provide training to all staff on information governance.
- Ensure that all GPs are trained to Level three in Safeguarding Children
- Update the emergency medicines checklist to ensure that the contents annotated reflect those that are currently available.
- Introduce a single system to ensure that NICE guidelines are disseminated to all staff.
- Ensure that all patients with a learning disability have a care plan in place.
- Look at ways to improve access to appointments.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned from incidents and learning was communicated to staff using a monthly practice newsletter. Information about safety was recorded, monitored, appropriately reviewed and addressed. Policies and procedures to support safe practices were available to all staff on the practice website. Risks to patients were assessed and well managed and there were enough staff to keep people safe. All GPs were not trained to Level three in safeguarding children and some items of emergency medicines did not reflect those annotated on the contents list.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed that patient outcomes were above average for the locality. Guidance from the National Institute for Care and Health Excellence was available for staff to refer to and was used routinely. Patients' needs were assessed and care was planned to meet individual patient's needs. All patients over the age of 75 had a care plan in place but only one of the 21 patients with learning disabilities had a care plan in place. The practice had signed up to an enhanced service for patients with learning disabilities to improve this. Staff received appropriate training and staff had appraisals and development plans in place.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. We saw that patients were treated with dignity and respect. The practice ran a 'tea and chat' service for older people that was aimed at the reduction of social isolation. This service was used to provide health information to patients such as safe sun advice.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of the local population and liaised with the NHS England Area Team and clinical commissioning group to secure improvements in areas identified. The practice had responded to information raised by patients and implemented a sit and wait

Summary of findings

service in response to feedback that it was difficult to book an appointment. Information about how to complain was available to patients and learning from complaints was shared with staff using a staff newsletter.

Are services well-led?

Good

The practice is rated as good for being well-led. Staff were clear about the practice vision and their responsibilities in relation to this. There was a clear leadership structure and staff told us they felt supported. Union representatives had been encouraged to visit the practice to talk to staff and provide them with information about their services. There were a number of policies and procedures in place and a staff handbook. These were available to all staff on the practice computer system. There were systems in place to monitor and improve quality. The practice sought feedback from staff and patients and responded to this information.

Summary of findings

The six population groups and what we found

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

Older people

Good

The provider is rated as good for providing care to older people. They offered proactive personalised care to meet the needs of older people in its population group and had a range of enhanced services. For example, the practice had successfully bid for funding to provide an over 75's service and had employed a care coordinator to manage the care provision to people over the age of 75 using an integrated approach and working within multi-disciplinary teams including social services, community services and organisations within the voluntary sector.

People with long term conditions

Good

The practice is rated as good for providing care to people with long-term conditions. Patients with long-term conditions had reviews and there was a system to recall patients with long-term conditions for their reviews. The practice provided a holistic approach to patient care and staff were supported by a respiratory nurse and a diabetes nurse specialist from Dorset County Hospital. Nurses had undertaken training to assist in the management of specific conditions such as asthma, chronic obstructive pulmonary disease (COPD) (the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease) and diabetes.

Families, children and young people

Good

The practice is rated as good for providing care to families, children and young people. The practice worked with a specialist paediatrician, health visitors and midwives to deliver care using a multi-disciplinary approach. The practice had a designated lead for child protection and GPs attended child protection case conferences where children had been identified as being at risk. The practice provided childhood immunisations and the percentage of children receiving immunisations was above the national average. There were appointments available outside of school hours for children.

Working age people (including those recently retired and students)

Good

The practice is rated as good for providing care to working age people (including those recently retired and students). The needs of this group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, the practice offered

Summary of findings

appointments until 8pm on Mondays and Thursday and appointments were available on a Saturday morning at the branch surgery between 8.30am and 11.30am. Emergency appointments were available on a daily basis and telephone consultations were available instead of patients attending the practice. The practice offered online prescription ordering with a 48 hour turn around and appointments could be booked online up to six weeks in advance.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for providing care to people whose circumstances may make them vulnerable. The practice was contracted to provide a directed enhanced service to patients with learning disabilities. All patients who had been identified as vulnerable were highlighted using the practice computer system and the practice held a register of vulnerable patients, which was updated on a regular basis. Vulnerable patients had been allocated to a named GP. The practice had used a range of criteria to determine vulnerability, for example, a high number of hospital admissions, learning disability, were at risk of social isolation or had been referred to the community matron. Patients who were vulnerable had a care plan in place. However this did not apply to all of the patient population who were considered to be vulnerable. The practice provided tea and chat sessions to reduce social isolation and used these sessions to provide information to patients on topics such as fire safety, fraud, sun safety and nutrition.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for providing services to patients experiencing poor mental health, including dementia. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health and sign posted patients to appropriate services, For example, the practice worked with a clinical psychologist, community mental health team, drug rehabilitation teams and hosted a local steps to wellbeing service. The practice provided a directed and enhanced service for facilitating timely diagnosis and support for people with dementia and used screening tools to identify patients at risk. The practice referred patients to memory gateway services, which are services provided by a partnership between a designated charity and a Health Care agency.

Summary of findings

What people who use the service say

As part of our inspection process, we asked patients to complete comments cards prior to our inspection. We received 15 comments cards, spoke with two patients and two members of the patient participation group (PPG). Patients indicated that the care they received was very good and that they were treated with dignity and respect. However patients indicated that it was sometimes difficult to make an appointment.

Our findings were in line with the results of the friends and family test. A total of 112 patients responded to the test between 1 December 2014 and 15 January 2015 and 90% of patients were either likely or extremely likely to recommend the practice to their friends and family and 10% were either neither likely or unlikely to recommend the practice to their friends and family. The key area of concern was found to be unavailability of appointments.

We reviewed the results of the national GP patient's survey for the period January to March 2014 and July to September 2014. 115 patients responded to the survey. Results from this survey identified:

- 81% of patients described their overall experience of this surgery as good compared with the clinical commissioning group (CCG) average of 89.1% and the national average of 67.9%.
- 96% of patients said that they had confidence and trust in the last GP they saw or spoke to compared with the CCG average of 93.9% and the national average of 92.2%.
- 99% of patients said they had confidence and trust in the last nurse they saw or spoke to compared with the CCG average of 86.5% and the national average of 85.5%.
- However only 55% of patients described their overall experience of making an appointment as good compared with the CCG average of 81.9% and the national average of 73.8%.

In response to the shortage of appointments, the practice had introduced a system were patients could arrive at 8.30am on a Monday, Wednesday and Friday and sit and wait to be seen. The patients that we spoke with indicated that they liked this service as they knew they would have to wait but they also knew that they would be seen on that day. This service had been advertised in the Portland News and in the practice newsletter.

Areas for improvement

Action the service SHOULD take to improve

- Provide training to all staff on information governance.
- Ensure that all GPs are trained to Level three in Safeguarding Children.
- Update the emergency medicines checklist to ensure that the contents annotated reflect those that are currently available.
- Introduce a single system to ensure that NICE guidelines are disseminated to all staff.
- Ensure that all patients with a learning disability have a care plan in place.
- Look at ways to improve access to appointments.

Outstanding practice

We saw one area of outstanding practice:

The practice provided a 'tea and chat' service for patients who were isolated. The sessions were used to provide health advice to patients on matters such as sun safety.

Royal Manor Health Care

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) inspector and the team included a GP specialist advisor and a practice manager specialist advisor.

Background to Royal Manor Health Care

Royal Manor Healthcare is situated on Park Estate Road, Easton, Portland, Dorset, DT5 2BJ. The practice is located in purpose built premises. At the time of our inspection there were 12,259 patients on the practice list. The practice has seven GP partners, a salaried GP, four nurses, a healthcare assistant, a practice manager, reception and administration staff. Five of the GPs are male and three are female. The practice has a branch surgery at Gatehouse Surgery, Castle Road, Portland, Dorset, DT5 1AU. We did not inspect the branch surgery as part of this inspection.

The practice is open between 8.30am and 12.30pm and between 1.30pm and 6pm Monday to Friday. Extended opening hours are available on a Monday and Thursday until 8pm and patients can book appointments at the Gatehouse branch surgery on a Saturday morning between 8.30am and 11.30am. There is an emergency doctor on duty from Monday to Friday between 8am and 8.30am, 12:30pm and 13:30pm and 6pm and 6.30pm.

Patients requiring to see a GP out of working hours can contact an external Out of Hour's service that is provided at a local NHS Walk-In Centre. The walk-in centre is open seven days a week from 8am – 8pm . Patients can also access emergency treatment out of hours, provided by South West Ambulance Service and can access care using 111. The practice has a General Medical Services (GMS) contract (a contract between NHS England and general practices for delivering general medical services and is the commonest form of GP contract).

Why we carried out this inspection

We carried out a comprehensive inspection of the services under section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. We carried out a planned inspection to check whether the provider was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to provide a rating for the services under the Care Act 2014.

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

How we carried out this inspection

Before visiting the practice we looked at information we held and asked other organisations and key stakeholders to share what they knew about the practice. We reviewed policies, procedures and other information the practice provided before the inspection day. We carried out an announced visit on 24 June 2015. We spoke with a range of staff including GP partners, practice nurses, reception staff and administration staff. We sought views from patients and from representatives of the patient participation group. We reviewed comments cards and survey information.

Detailed findings

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

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

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

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a significant event that had been reported in December 2014 had been reviewed at a significant events meeting on 16 February 2015. Records indicated that action was taken following the event and an immediate staff meeting was convened that all staff were expected to attend. The incident had indicated that a procedure needed to be reinforced to staff and all staff had been sent a personal letter outlining the correct procedure to follow should the situation arise again.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over this time and could show evidence of a safe track record.

Learning and improvement from safety incidents

There was a system in place for reporting and recording significant events. The practice used a significant events form and held a record of all significant events reported. This information was available to all staff on the practice computer system. We saw that 35 significant events had been recorded in the past year. Each record was given a unique identification number and was tracked using a spreadsheet. The significant events records identified the date that it had been reviewed at a significant events meeting and individual reporting forms contained details of actions and lessons learned. For example, a significant event was reported in March 2015 and the outcome was clearly documented. This was discussed and closed at the next significant events meeting in May 2015. We saw from significant events records that meetings were held every three months. Where appropriate, the patients were provided with a detailed summary of findings of the significant events analysis. Meetings were attended by GPs, nurses, the practice manager and the lead receptionist. The practice manager communicated with all staff using a monthly newsletter, which was also used to disseminate key learning points from significant events.

The practice had a system in place to implement safety alerts from the Medical and Healthcare Regulatory Agency (MHRA), which were sent to the practice manager and disseminated to practice staff by e-mail. The practice manager's mailbox was shared with the deputy practice manager so information could be cascaded during any periods of absence.

Reliable safety systems and processes including safeguarding

The practice had a safeguarding vulnerable adults and children's policy in place which was available to staff on the practice computer. The practice had a nominated lead in safeguarding and staff we spoke to said that if they had concerns about a patient they would raise them with the named lead. We were told that reception staff and the care coordinator for over 75s care had raised safeguarding concerns about patients that they had identified as vulnerable.

All staff had received safeguarding children training but all GPs had not received training to level three, which was appropriate for their role, however the safeguarding lead had been trained to this level. All staff had received safeguarding vulnerable adults training. Staff attended multidisciplinary safeguarding meetings that included GPs, nurses, community matron, health visitors, midwives, and a community psychiatric nurse and these meetings were minuted. GPs met with a paediatrician on a monthly basis to discuss children who were at risk but this meeting was not minuted. School counsellors would also identify to the practice if they thought that a child was vulnerable. The practice had a computer system for patients' notes and there were alerts on a patient's records if they were at risk or subject to child protection.

There was a chaperone policy available on the practice computer system. There was information available to patients within the practice about how to request a chaperone but no information available to patients about how to request a chaperone on the practice website. Staff had received training in chaperoning and could identify the

procedure they used to safeguard patients when chaperoning them. Staff who chaperoned patients had either received a check from the Disclosure and Barring Service (DBS) or this requirement had been risk assessed.

Medicines management

The practice had a nominated prescribing lead who was responsible for ensuring that updated guidance was implemented. The lead was able to identify how patient's medication records were identified and updated in response to new guidance. A GP sat on a local committee that ensured collaboration between GPs and pharmacists to provide the best outcomes for patients. We reviewed a clinical audit that had been undertaken as a response to information indicating that some antibiotic prescribing rates were higher than national averages at 7.54% compared to the national average of 5.57%. Data had been reviewed to identify those GPs with higher prescribing rates and a clinical meeting was held to discuss this information. A second audit cycle indicated that prescribing rates had been reduced in line with national averages.

The practice had two refrigerators for the storage of vaccines. The lead nurse took responsibility for the stock controls and refrigeration temperatures. All vaccines and medications were checked monthly to ensure that they were within their expiry date and vaccines that we checked were in date. There was a procedure in place for managing the cold chain of vaccinations and refrigeration temperatures were checked daily (cold chain refers to the process used to maintain optimal conditions during the transport, storage, and handling of vaccines, starting at the manufacturer and ending with the administration of the vaccine to the client). Checks were audited every three months to ensure that they had been completed and actions identified as a result of the audit were completed. There was a procedure to follow in the event of refrigeration failure that had been put in place in response to a previous incident that had occurred when the cold chain was not maintained and vaccinations had to be discarded.

Nurses administered vaccinations using patient group directives (written instructions for the supply or administration of medicines to groups of patients who may not be individually identified before presentation for treatment). Patient group directives were available and signed by nurses. Travel vaccinations and vitamin B12 injections were administered using patient specific directives (written instruction, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis). The healthcare assistant did not administer any vaccinations.

Emergency medicines such as adrenalin for anaphylaxis were available; however some quantities available were different from the quantities recorded on the emergency medication checklist. For example, the checklist indicated that there should be four pre-filled syringes containing Adrenaline 1:10,000 but there were only three available in the box. Some needles were also not recorded on the checklist. This means that they could be removed without the knowledge of staff. There was a separate box containing a protocol and items for the management of hypoglycaemia (low blood sugar).

All prescriptions were reviewed and signed by the GP before they were given to the patient and there was a procedure in place for the management of repeat prescriptions that could be received electronically or as a paper copy. The procedure included how to manage patients requiring a medication review and patients who failed to attend for a medication review. Blank prescriptions forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

All areas within the practice were found to be clean and tidy. Patients commented that the practice was clean and tidy.

Treatment rooms had the necessary hand washing facilities and personal protective equipment such as gloves and aprons were available. Hand hygiene audits were completed every six months.

The practice nurse was the designated infection control lead and there was a comprehensive infection control policy and guidelines, which were available to all staff on the practice computer system. All staff had completed infection control training. The majority of equipment used was disposable and clinical waste disposal contracts were in place.

The infection control lead completed six monthly audits of infection control procedures in line with the requirements

Good

Are services safe?

of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance 2010. Environmental cleaning was carried out by a contracted company and there was a schedule of cleaning in place for contract cleaners to follow. The practice manager completed spot checks of environmental cleaning. There was a record of cleaning checks completed for each room in the practice and any deficiencies identified were discussed with the cleaning service provider.

There was a procedure in place for the management of legionella (legionella is a term for particular bacteria which can contaminate water systems in buildings) and checks had been completed in line with the legionella risk assessment (a report by a competent person giving details as to how to reduce the risk of the legionella bacterium spreading through water and other systems in the work place).

Equipment

All equipment was checked to ensure that it was safe to use. Portable electrical appliances were inspected and tested in May 2015.

Clinical equipment was checked to ensure that it was working properly. For example the electrocardiogram machine (used to check the function of the heart) was tested in October 2014. Staff that we spoke with told us that they had sufficient equipment to carry out their role effectively.

Weekly checks were completed on emergency equipment such as the defibrillator and checks were completed on emergency oxygen cylinders.

Staffing and recruitment

There were enough staff to meet the needs of the patients. Staff covered each other during periods of absence and locum GPs were used if required. A locum GP worked at the practice every Monday in response to a high demand for appointments after the weekend.

The practice had a recruitment policy that set out the standards that it followed when recruiting clinical and non-clinical staff. All permanent staff working at the practice were risk assessed to identify whether a DBS check was required. DBS checks had been completed for all clinical staff and some non-clinical staff in accordance with the risk assessment.

Monitoring safety and responding to risk

There were procedures in place for monitoring and managing risks to patient safety. A Health and Safety Policy was available to all staff on the practice computer system. Risk assessments were in place and all staff were trained in how to instigate and conduct a risk assessment should the need arise. All new employees working in the building were given a documented induction process, which included information about health and safety and fire safety. All staff received training in fire safety and in slips, trips and falls.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computer systems that were in all consultation and treatment rooms which alerted staff to any emergency. There was also a panic alarm in reception and in the small office that was used for private discussions with patients. Staff had received training in medical emergencies and there was emergency equipment on the premises. The practice also had nominated and trained people to provide first aid treatment.

Fire appliances had been tested and four staff had been nominated and trained to act as fire wardens. The practice had a plan in place for business continuity that outlined the procedures to be taken in the event of emergencies that could impact on the operational ability of the practice.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

All patients received a full health check on registering as a patient at the practice. The check included discussing information about the patient's lifestyle as well as their medical conditions and was usually carried out by a nurse. If the nurse required additional checks to be completed the patient would be seen by a GP.

The GPs and nurses we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. NICE guidance and local guidance for the management of some conditions were displayed in treatment rooms. NICE guidelines were used to inform monthly clinical meetings which could be attended by nurses and a pharmacist. However there was no single system in place to disseminate updates on NICE guidelines to all clinical staff and identify any action that had been taken as a result of the new guidance.

The practice used the clinical record system to identify patients who were vulnerable. The practice held registers to identify patients with long-term conditions, patients who required palliative care, patients who were carers, patients with learning disabilities and patients experiencing poor mental health, including those with anxiety and depression. Palliative care meetings were held every two months and palliative care was provided in line with the Gold Standard Framework for end of life care.

The practice took part in the avoiding unplanned admissions scheme. People who were identified as high risk of hospital admission had their care reviewed at multi-disciplinary team meetings and the over 75s care coordinator also worked with other agencies such as district nurses and voluntary sector organisations to prevent hospital admissions. All patients over 75 had care plans in place, however there were 21 patients identified as having learning disabilities and only one of these patients had a care plan in place and there were 109 patients identified as experiencing poor mental health, of which 29 had a care plan in place. The practice were aware of this and informed us the partners had signed up to a local enhanced service and were about to proceed with a system of recall for all patients on the learning disabilities register. Patients would be given complete care reviews and have care plans completed.

Management, monitoring and improving outcomes for people

The practice participated in the Quality and Outcomes Framework (QOF). This is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions, for example, diabetes and implementing preventative measures. The results are published annually. QOF data for the period 2013/2014, indicated that the practice had achieved 95.6% of the total QOF points available. This is higher than the national average of 94.2%.

GPs were involved in completing clinical audits. Examples of clinical audits reviewed included an audit to identify those patients at risk who had not received a pneumococcal vaccination, which protects against streptococcus pneumonia infections such as meningitis. An audit of patient records identified those patients at risk who had not been vaccinated. Patients were contacted and this led to increased rate of vaccinations. Other audits included those to identify whether patients using lithium medication had been correctly recalled for review in accordance with NICE guidelines. Audits following minor surgeries, such as vasectomies were completed to identify whether there had been any post-operative complications and to identify whether there were any areas where the patient experience could be improved.

The practice also arranged a "tea and chat service", that was organised in conjunction with the patient participation group and over 75s coordinator. This service was aimed at reducing social isolation for those patients that lived alone and preventing conditions associated with social isolation, such as depression. The event was also used to provide health information to patients such as sun awareness.

The practice held a General Medical Services contract and also provided a number of Clinical Commissioning Group enhanced services, such as childhood immunisations and facilitating timely diagnosis and support to patients with dementia.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

The practice had an induction programme for newly appointed members of staff that covered key areas such as health and safety, complaints, significant event reporting and infection control. There was a staff handbook available to all staff on the practice computer system.

Staff received training that included safeguarding children and vulnerable adults and basic life support. However some staff had not received training in information governance and this had been identified using the practice training schedule which demonstrated what training staff had received and what training was required. Protected time was available for staff training and the practice closed to accommodate training that was organised by the clinical commissioning group.

All GPS were up to date with their continuing professional development and had been revalidated. (Every GP is appraised annually, and undertakes a full assessment called revalidation ever five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practice and remain on the performers list with NHS England). GPs do additional training to support their specialist roles. For example, a GP who provided vasectomies completed specialist training in July 2010 and attended a training update conference annually. Two GPs had training in substance misuse and a two weekly community drug prescribing service was carried out from the practice, including controlled prescribing of methadone.

The lead nurse arranged training for practice nurses and training was provided to support their specialist roles. For example, two nurses had completed training in diabetic foot screening. The lead nurse had a weekly meeting with the practice manager and other meetings such as partners meetings, nurses meetings and reception meetings were held monthly. Meetings for all staff were held on a quarterly basis. The practice also had lunch and learn sessions, which provided informal learning for staff.

All staff had annual appraisals and staff told us that they felt well supported and those staff who had completed training told us that they received mentoring and support from other staff.

Working with colleagues and other services

The practice received information from other organisations involved in providing care to patients. It received blood test results, X ray results, and letters from the local hospitals including discharge summaries, information from out-of-hours GP services and the 111 service both electronically and by post.

The practice had documented procedures in place outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Information was either received electronically or scanned onto the practice computer system. The information was sent as a task to the named GP for review. If further action was required, for example if a patient required a follow-up appointment , a task was sent to reception staff

Patients were referred to hospital using the 'Patient Choose and Book' system and patients were supported by staff to use this service if required. Urgent referrals, such as cancer referrals, were sent by fax. The practice used the two week rule and had systems in place to ensure that patients received appointments within the appropriate timescale. For example, a referral was sent on 15 May 2015 and the patient had received a scan and had been seen by the consultant within 13 days.

The practice liaised with other healthcare professionals when providing care, such as the community matron, midwives, community mental health teams and the 'Steps to Wellbeing' service. The practice worked with charities and voluntary organisations to provide care and support to patients, especially those that were isolated within the local community.

Information sharing

Systems were in place to ensure information regarding patients was shared with appropriate members of staff. All patients had an electronic care record that could be accessed by all clinicians. Alerts were placed on clinical records to inform staff if a patient was at increased risk, for example if they had a long-term condition or were a carer. Clinical meetings were held between GPs to discuss clinical cases and multi-disciplinary team meetings were held to discuss the care of patients who were vulnerable.

The practice provided a leaflet to patients about information sharing and patients were asked for their consent for staff to produce a summary care record that could be shared between healthcare settings. Information for patients receiving palliative care was shared with out of hours care providers by e-mail.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

The practice had a policy in place to help staff with determining the mental capacity of patients. The four main principles of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS) were available as a card in all surgeries. Training in Mental Capacity Act 2005 and DOLS was provided to all staff as part of safeguarding children and vulnerable adults training.

We spoke with GPs about their understanding of the Mental Capacity Act 2005 and Gillick Guidelines and staff understood key parts of the legislation and were able to describe how they implemented it in their practice. Gillick competence is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Mental Capacity 2005 and Gillick Guidelines were also discussed at clinical meetings. We spoke to a receptionist, who was aware of Gillick Guidelines and identified that they would book a young adult in for an appointment with the GP and the GP would assess Gillick competence.

The practice had a consent policy that was available to all staff on the practice computer system. Patient's expectations were discussed prior to treatment being provided and options for treatment were discussed with the patient. Consent to vaccinations was obtained verbally and recorded on the electronic patient record.

Health promotion and prevention

The practice had information available to patients to help them manage and improve their health. There was health promotion information available for patients. The practice had a separate health education room that could be used by staff and contained information leaflets on key health issues. The room was also used by health visitors for baby clinics and health education sessions for patients as part of the "tea and chat" initiative.

The practice signposted patients to additional services such as the young person's eating disorder service. Smoking cessation was discussed at the new patient health check and a 'Smoke Stop' service was provided by the local pharmacy.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous, caring and helpful to patients attending the practice.

We received 15 comments cards and spoke with two patients. Patients indicated that the care they received was very good and that they were treated with dignity and respect. Results from the national GP patient survey indentified as follows:

- 81% of patients indicated that the last GP they saw or spoke to was good at treating them with care and concern and this was in line with the national average of 82.7% and the CCG average of 85.9%.
- 90% of patients indicated that the last nurse that they spoke to was good at treating them with care and concern, compared to the national average of 78% and the CCG average of 79.2%.

Consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. Reception staff told us that if a patient wanted to have a confidential discussion they would use a private room at the side of reception.

The practice had a confidentiality policy that was available to patients on the practice computer system. Staff had training in information governance but not all staff were in date for this training.

People who were vulnerable were supported to attend the practice. Patients that were homeless were supported to access care and the practice address was used as a point of contact for correspondence, such as hospital appointments.

Care planning and involvement in decisions about care and treatment

Results from the national GP survey for the period January to March 2014 and July to September 2014 identified that:

- 77% of patients indicated that the last GP they saw or spoke to was good at involving them in decisions about their care and this was higher than the national average of 66.2% and the CCG average of 66.1%.
- 78% of patients indicated that the last nurse they saw or spoke to was good at involving them in decisions about their care. This was higher than the national average of 66.2% and the CCG average of 66.1%.
- 85% of patients indicated that the last GP that they saw or spoke to was good at explaining tests and treatments compared to the national average of 82% and the CCG average of 84.1%
- 91% of patients said that the last nurse that they saw or spoke to was good at explaining tests and treatments compared to the national average of 76.7% and the CCG average of 77.6%.

The practice took part in an unplanned admissions scheme and a staff member identified that many patients over the age of 75 were supported to receive care in their own home as this was their choice. This involved working with other healthcare professionals, including district nurses and a specialist who assisted to prevent falls and worked with support and voluntary organisations.

The majority of the practice population spoke English as a first language but translation services were available. Staff told us that there had been no previous requirement to use this service.

Patient/carer support to cope emotionally with care and treatment

The chairs in the reception area had been moved to ensure that patients could not be heard when talking to reception staff. There was a private room next to reception that staff could use when patients wanted to have a more private conversation. We were advised that this room had a panic button installed and staff would use it to have private conversations with patients who had become volatile.

There was supporting information to help patients who were carers on a board in the waiting room and the practice held carers support group meetings. The practice kept a list of patients that were carers and alerts were placed on the patient record to identify patients that had a caring responsibility and may require extra support.

The practice provided 'Tea and Chat' sessions aimed at reducing social isolation and helping to reduce those

Good

Are services caring?

medical conditions that were associated with social isolation, such as depression. Staff told us that some patients had gone on to take part in community action groups like exercise classes.

The GP contacted families who had suffered bereavement by telephone and the practice sent a sympathy card to the family. Patients who had suffered bereavement were supported to access support organisations.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients' needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, there were no care homes on Portland and the over 75s service had been implemented to improve care provided to an increasing number of older patients who wanted to receive care in their home.

The practice engaged regularly with the NHS England Area Team, clinical commissioning group and other practices to discuss local needs and service improvements that needed to be prioritised. Information on the practice website informed patients that the practice was part of a federation of practices that enabled them to work more closely together to share expertise, resources and provide or commission services for the NHS.

The practice had an established patient participation group (PPG) of 30 members and a virtual PPG of 121 members, but they were still trying to recruit members that were representative of the whole patient population. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). A PPG report dated 30 March 2015 indicated that key issues included a lack of appointments and a poor quality telephone service. The practice had introduced rapid access clinics on three days per week which allowed patients to sit and wait to be seen by a GP. The practice had researched options for an updated telephone system but this cannot be implemented until the current telephone contract expires in December 2015.

Tackling inequity and promoting equality

The practice had very few patients for whom English was not their first language but the practice had access to translation services. Staff were aware of patients that needed extra support and used picture books to communicate with patients who had learning disabilities.

The premises and services had been adapted to meet the needs of people with disabilities and there were seven consulting rooms on the ground floor of the practice. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff had received training in Equality and Diversity and there was an Equality and Diversity Policy that was available to all staff on the practice computer sytstem.

Access to the service

The practice was open between 8.30am and 12.30pm and between 1.30pm and 6pm Monday to Friday and provided extended opening hours on a Monday and Thursday until 8pm and at the Gatehouse branch surgery on a Saturday morning between 8.30am and 11.30am. An emergency doctor was on duty from Monday to Friday between 8am and 8.30am, 12:30pm and 13:30pm and 6pm and 6.30pm. Routine appointments could be booked six weeks in advance and emergency appointments were offered each day to support patients who needed to be seen urgently.

The GP survey indicated that:

- 77% of patients said that they were able to get an appointment or speak to someone the last time they tried and this was low compared to the national average of 85.4% and the CCG average of 89.6%.
- 68% of patients said that they were satisfied with the surgery's opening hours and this was lower than the national average of 75.7% and the CCG average of 75.7%.

In response to patient feedback, the practice had introduced a rapid access service and extended opening hours. The patients that we spoke to were positive about the rapid access service as they knew they would see a GP on the day of their choice.

The practice provided telephone advice to patients and provided home visits to those patients who were housebound or too ill to attend the practice. Patients who are unable to access the surgery were identified on the vulnerable patients list. These patients were seen by a Health visitor every two weeks and patients had care plans in place.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. Out of hours care was provided by South West Ambulance Trust and could be accessed using the 111 service and patients could attend the walk in centre in Weymouth.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints. 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, who was supported by a lead clinician and lead nurse.

Information was available about how to make a complaint on the practice website and there was a practice leaflet outlining the complaints process that was easily accessible to patients. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 49 complaints received in the last 12 months and found that these were satisfactorily handled and dealt with in a timely way. There was openness and transparency in dealing with complaints. A letter was sent to all complainants to identify the action that had been taken by the practice.

The practice reviewed complaints as part of the significant events process and lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. Complaints were discussed at monthly clinical meetings and at significant events meetings that were held every three months. Trends in complaints had been reviewed and changes to procedures had been actioned in response to complaints received. The practice manager used the monthly practice newsletter to promulgate learning from complaints to staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The Statement of Purpose for the practice indicated that the practice vision was to work in partnership with patients, community teams and staff in order to provide the best primary care service possible. This was corroborated by staff who told us that the practice vision included providing a comprehensive service to the patient population and continuing to offer the current services such as joint injections and minor surgery. The practice did not have a five year business plan but the practice vision was discussed at partners' meetings.

Comments from patients indicated that they were happy with the standard of care they received and patients were consulted and given choices about their care. The practice had responded and made changes to the service in response to feedback from patients.

Governance arrangements

The practice provided comprehensive policies and procedures which were available to all staff on the practice computer system. Policies had been reviewed and updated.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP was the lead for safeguarding. Staff that we spoke with were all clear about their own roles and responsibilities and told us that they were encouraged to undertake additional training so that they could support other staff in their roles. Staff told us they felt valued, well supported and knew who to go to in the practice with any concerns. Union representatives had been encouraged to visit the practice to talk to staff and provide them with information about their services. The practice also had a monthly newsletter that was distributed to all staff. The newsletter included information about learning from complaints and significant events but also provided a form of communication between departments as well as announcing any special events that were pertinent to staff.

The practice used the Quality and Outcomes Framework to measure its performance and QOF data for 2013 -2014 indicated that the practice had achieved 95.6% of the total points available. The practice had a designated lead for the management of QOF and data was reviewed to identify areas that could be improved.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Staff with different roles were encouraged to work together to resolve issues and this provided an appreciation and understanding of each other's roles.

We saw from minutes that individual team meetings for GPs, nurses and reception staff were held every month and that whole team meetings were held every three months. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues, felt confident in doing so and felt supported if they did. Social functions such as staff barbeques were held. Staff said they felt respected, valued and supported.

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

The practice gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG but identified that the group was not representative of the whole patient population. PPG surveys had been used to identify areas that needed to be addressed and the practice had responded to this information. For example, a PPG survey identified that social isolation amongst elderly patients was a key concern and the practice had worked with the PPG to instigate 'Tea and Chat' sessions for isolated patients.

There was a suggestions box in the waiting room and we saw that patients' suggestions had been actioned. A patient had suggested that blood donor cards should be available for patients and these had been made available in the waiting room.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing and had taken action in

Are services well-led?

Good

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

response to the survey results, For example the rapid response system had been introduced, where patients could sit and wait to see a GP, in response to feedback that it was sometimes difficult to get an appointment.

The practice had also gathered feedback from staff through an annual staff survey, through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us that were encouraged to undertake training and that they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Practice staff were encouraged to work together as a team and staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff had appraisals and GPs had completed the revalidation process. Nurses told us that they had arranged training with regard to the revalidation process for nurses which was being instigated by the Nursing and Midwifery Council. Formal meetings were in place to support shared learning. For example, clinical meetings were attended by GPs and nurses and significant event meetings were attended by GPs, the lead nurse and the lead receptionist. There was evidence that learning had occurred as a result of significant events and complaints and we saw that this learning had been shared with all staff using a newsletter.

We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training