Wyke Regis Medical Practice

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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Summary of findings

Overall summary

Wyke Regis Medical Practice is a GP practice providing primary care services for people in and around Wyke Regis, Dorset. It is registered to deliver a range of services including diagnosis, screening and treatment, minor surgery, family planning, maternity and midwifery services. The practice has a total of seven GPs supported by a nursing team and an administration team for approximately 8,000 registered patients. It is also a GP training practice providing educational development for new GPs. Opening times are Monday to Friday from 8.30am to 6.30pm. Late appointments are offered on Monday evenings until 7.30pm, and early appointments on Tuesday mornings from 7.30am. The practice is closed at lunchtimes between 1 – 2 pm.

Wyke Regis Medical Practice has one location registered with the CQC. This is at Wyke Regis Health Centre, Portland Road, Wyke Regis, Dorset DT4 9BE where we carried out our announced inspection visit on 6 June 2014.

The practice provided a service that was caring, responsive and well-led. There are areas needing improvement to ensure the safety of the service 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 the practice was safe but some improvement was needed.

Significant events were recorded. These were shared within the practice as a means of learning, and improvements were made to ensure safety standards were maintained.

Reception staff employed since April 2014 had a criminal record checks but this varied for reception staff employed in the past five years. There were no risk assessments in place for staff who had not had a criminal record check. On occasions reception staff were used as chaperones. This put patients at risk if reception staff who had not had a criminal records check were used as chaperones.

Are services effective?

The practice was effective.

The practice had a system in place to ensure the right skill mix and staffing levels were in place to provide an effective service at all times.

Information about individual patients was shared with other healthcare providers such as the out of hours service, midwives, community nursing teams, and palliative care teams.

Patients were provided with information leaflets about their health needs and to support them in making decisions about their treatment. They were also signposted to relevant agencies and services for advice and support. This supported the continuity of the patient's care and patients could be confident that the practice actively engaged with other service providers to ensure they received effective care.

Are services caring?

The practice was caring.

All the patients we spoke with and the comments we received were complimentary of the care and service staff provided. They told us they were involved in decisions about their care and treatment and were provided with information to help in making these decisions.

Patients were referred appropriately to other support and treatment services. The Out of Hours service was notified of any pertinent information about individual patients in the event it was contacted by or about the patient.

Summary of findings

There were opportunities for patients to provide feedback about the care and treatment they had received. Patient confidentiality was respected and maintained.

Are services responsive to people's needs?

The practice was responsive to patients needs.

Patients individual needs were met without avoidable delay.

The practice recognised the need to provide a flexible service to meet the needs of patients with caring responsibilities.

There was an open culture within the practice with a complaints and feedback system in place. The practice learned from the experiences, concerns and complaints of patients and made changes to improve the quality of care it provided.

Are services well-led?

The practice was well-led.

There were organisational structures in place with clear lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The practice promoted an open and fair culture.

The practice offered a service that was of good quality through clinical governance and systems in place to provide on going monitoring.

There were aspects of safety that were compromised because different staff teams were not clear about practice procedures and the pathways that should be followed.

Staff and clinicians received an annual appraisal to discuss their performance and issues relating to their role. Regular meetings were held where staff were encouraged to contribute their ideas, suggestions and concerns.

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

Nursing staff were trained and experienced in providing care and treatment for medical conditions affecting older people. The practice worked with partner agencies and services, for example, they provided care and treatment at six care homes for older people. They also worked with community nursing teams to ensure older patients received safe and effective care and treatment. A multi-disciplinary meeting was held monthly to review care and treatment of older patients who were considered to be vulnerable due to their poor physical and or mental wellbeing. Feedback we received indicated that the GPs treated their older patients with respect and dignity, and were not patronising towards them.

People with long-term conditions

The practice cared for patients with long term conditions including asthma, diabetes, and heart disease. Patients were able to book routine appointments with the practice nurse or a GP for monitoring and treatment of their conditions. It worked to the Quality and Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement. Wyke Regis Medical Practice achieved good results in relation to enhancing the quality of life for people with long term conditions.

Mothers, babies, children and young people

The practice ran a number of clinics including child health surveillance and immunisations. It promoted public health information and sexual health screening for young people.

The GPs, nurses and staff knew what to do in the event they were concerned a child was at risk of significant harm.

The working-age population and those recently retired

The practice opened late one evening and early one morning a week to provide a more accessible service for patients who were working during the day.

As part of the new patient registration service, anyone who was a carer had this flagged on their patient record. This system alerted the reception staff to accommodate these patients with appointments that suited their caring arrangements. Patients who were carers were also provided with signposting information to various services.

Summary of findings

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

The practice held monthly multi-disciplinary meetings to discuss and review the care and treatment of its identified vulnerable patients. Additional best interest meetings were also held when they were required for patients assessed as not having mental capacity to make an informed decision about their care and treatment.

The staff told us that if anyone asked to be seen at the practice and they did not have their own address, the patient would be registered care of the practice. Any hospital letters for example, would then be received at the practice and the patient could collect them.

At the time of our inspection the practice did not have any registered patients who did not speak English. The staff told us they had access to a telephone interpretation service should they need this.

Patients with a learning disability were offered additional support for accessing the system to make hospital appointments.

People experiencing poor mental health

The practice worked with statutory mental health and social care teams to ensure patients experiencing mental ill health received appropriate support. GPs were able to make direct referrals to these services.

Summary of findings

What people who use the service say

We spoke with nine patients and received written feedback from two more patients. The majority of patients were more than satisfied with the service provided by the practice. They told us that GPs were respectful and took time to listen even if the routine ten minute appointment was overrunning. Patients also told us that the nursing team was very helpful and positive. Patients told us they were involved in decisions about their treatment and given extra written information leaflets to take away to read. The majority of patients who had repeat prescriptions were satisfied with this service. Three patients told us that referrals to other services were made in a timely manner. Four patients did not know how to make a complaint however they said they would speak to a staff member or their GP if they had any concerns.

We received mixed views about the ease of making and getting appointments. Five patients complained about the difficulty with getting through on the telephone in the mornings. One patient said they used the online appointment booking system and this worked much better for them. Patients told us appointments generally were about a two weeks wait to see a named GP. All the patients we spoke with confirmed they could be seen on the day if they needed to see a GP urgently, and they could make follow up appointments up to eight weeks in advance.

The practice manager told us and we observed that five direct lines were allocated to staff to answer calls between 8.30 and 9am. This was to ease the length of time people were kept waiting on hold before speaking with a member of staff. We saw that most patients were offered an appointment within two days. For patients wishing to be seen on the same day and if no appointments were available, they were invited to sit and wait to see a GP at the end of surgery. Patients accepting this were advised their time slot would be for five minutes and for urgent reasons only.

Areas for improvement

Action the service MUST take to improve

All staff who assist a clinician in the role of chaperone must have a criminal record check or risk assessment to show why the role of chaperone does not require a criminal record check.

Action the service COULD take to improve

All staff should be clear about the pathways for how vaccines are received at the practice to ensure the safe arrival and storage of vaccines, and systems of recall for blood tests and review of repeat prescriptions if the patient's GP is absent.

Wyke Regis Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector and included a GP, a practice manager, an expert by experience and a second CQC inspector.

Background to Wyke Regis Medical Practice

Wyke Regis Medical Practice is located in a purpose-built building and provides care and treatment to 7821 patients living in and around Wyke Regis and Weymouth. It is in a seaside resort so additionally provides emergency care and treatment to holidaymakers. Outside normal surgery hours the emergency cover is provided by another service.

The practice considered its general patient population as predominantly white, middle class and English. There is a relatively low unemployment rate. The practice has a patient population mix of all ages. There is a lower percentage of the 18 years and younger age group than the England average, and a higher percentage in the 65 years and over age group compared with the CCG area and the England average. Wyke Regis Medical Practice has a higher income deprivation affecting older people score than the CCG area but lower than the England average.

Health care priorities in Dorset include anxiety, depression and dementia care, smoking, type 2 diabetes, circulatory disease, and harm caused by road traffic collisions.

Compared to the England population there are more people with a long term health condition or disability living in Dorset.

Homelessness has increased at a lower rate than the England average in Dorset. The practice had two patients who were homeless and registered with it at the time of our inspection.

Wyke Regis Medical Practice provides its services at Wyke Regis Health Centre, Portland Road, Wyke Regis, Weymouth, Dorset DT4 9BE.

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 the inspection site visit we reviewed a range of information that we had about the service. This included information from other organisations such as local Healthwatch, NHS England and Clinical Commissioning Group which shared with us what they knew about it, and information we requested from the provider. We sent comment cards to the practice for patients to share their views and experiences of the service. We received one comment card and also one email via our "Share Your Experience" web form.

We carried out an announced inspection visit on 6 June 2014 at the provider's registered location, Wyke Regis Health Centre, Portland Road, Wyke Regis, Weymouth, Dorset DT4 9BE. We spoke with the senior partner, the practice manager, four other GPs, three nursing staff, administration and reception staff who were working on

Detailed findings

the day of our visit. We looked at the arrangements in place for monitoring the presenting symptoms, diagnosis and treatment of patients. We observed how the service handled telephone calls and patients arrival at the surgery.

We spoke with nine patients attending appointments on the day of inspection. We also spoke with one patient from the Patients Participation Group (PPG). This is a group of volunteer patients currently being developed at the practice. Its purpose is to discuss the services offered and how improvements can be made which benefit the patients and the practice. The members of the groups are self-selecting by responding to a patient survey. We received one comment card from a patient and one email from another patient.

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 the practice was safe but some improvement was needed.

Significant events were recorded. These were shared within the practice as a means of learning, and improvements were made to ensure safety standards were maintained.

Reception staff employed since April 2014 had a criminal record checks but this varied for reception staff employed in the past five years. There were no risk assessments in place for staff who had not had a criminal record check. On occasions reception staff were used as chaperones. This put patients at risk if reception staff who had not had a criminal records check were used as chaperones.

Our findings

Safe patient care

We saw the practice had a Significant Event policy so staff were clear about how to manage these. We saw significant events were discussed at the GPs monthly meetings. Anything considered to be more serious was referred to the Risk Management Team at the Dorset Clinical Commissioning Group (CCG).

Staff told us patient complaints were treated separately to significant events. Complaints that were about a clinical matter whereby a patient considered their health had been compromised by a GP's actions or lack of action, were investigated by the practice. On occasion the General Medical Council (GMC) and or legal representation may also be involved on behalf of the patient with clinical complaints.

Learning from incidents

Significant events were discussed at the monthly GP meetings. The management team met weekly to review significant events. Learning outcomes were shared with the administration and reception staff at their monthly meetings.

Every clinical complaint was discussed at the monthly clinical update meetings which all clinical staff attended. Minutes were sent to all clinical staff and learning points from these meetings were sent to patients for information and transparency of communication.

We looked at learning from incidents where changes had been made to clinical and or administrative practice. Learning points from one significant incident, for example, were that if there was an incident, times should be noted. Also we were told screens were purchased as a means of ensuring dignity and privacy could be maintained if the incident occurred in a public area such as the waiting room.

Safeguarding

The practice had a nominated lead person for safeguarding children, and ensured appropriate knowledge and management of safeguarding incidents. We saw the policy on safeguarding children and vulnerable adults. This gave staff clear guidance, including a flow-chart to help when making decisions about action to take, and contact details for the local safeguarding team for making alerts about possible abuse. For vulnerable adults, their named GP took

the lead role. The practice training record showed four out of seven GPs had level 3 e-learning for child protection and the trainee GP had level 3 training arranged for mid June 2014. Four GPs had undertaken an accredited e-learning module for safeguarding adults. It was expected that all the GPs would have completed child protection safeguarding training to level 3 by the end of 2014.

Reception and administration staff had all completed a level 2 e-learning module staff, for which we saw certificates on individual staff personnel files. One receptionist confirmed they had received safeguarding training for adults and children to the required level for their role. We saw safeguarding flow charts for adults and children on a wall in the reception area with local contact telephone numbers. Staff were on the whole familiar with the process of what to do if they considered someone was at risk of harm or had been harmed.

The two healthcare assistants we spoke with confirmed they had undertaken safeguarding training for adults and children. This also included training about the Mental Capacity Act 2005. They said they would report any issues to the safeguarding lead for the practice. They both felt confident that any issues raised would be dealt with appropriately.

The practice manager told us staff feedback about online training had been poor. The practice had therefore introduced in-house training provided by the Local Medical Council (LMC). During this training staff were given scenarios to consider and discuss as a group. Feedback was positive about this style of training as it was more meaningful to real life situations.

All the staff we spoke with were familiar with the practice whistleblowing policy. They knew they could talk to someone if there were any issues and were confident what they said would be taken seriously and acted upon.

Medicines management

The practice had three refrigerators for storage of medicines, each in separate treatment rooms. Daily temperature monitoring was in place for all three refrigerators. We saw all recent records were within the required range of 2-8 degrees and recent checks had been carried out on each working day. This was an improvement from the recordings in December 2013 which were patchy although explanations were recorded when temperature checks had been missed.

We saw the practice had an electronic version of a vaccination storage policy available to staff. The practice nurse told us about a refrigerator in the reception area which could be used to store vaccines when they arrived to preserve the 'cold chain'. When we checked this refrigerator we saw it was situated adjacent to a radiator and there were no records of any temperature checks. Also the reception staff told us it was only used for specimens. They said vaccines were placed directly on arrival into one of the refrigerators in a treatment room as all treatment rooms would not be in use at the same time. There was not a clear understanding between different staff teams about the pathway for the receipt and safe storage of vaccines.

We looked at the general storage of medicines in the treatment room. A practice nurse explained and showed us documentation for checking expiry dates of medicines. The practice manager told us controlled drugs were not held at the practice. This was confirmed when we checked the controlled drugs storage cupboard which was empty, and entries in the controlled drugs record book were all at zero. The practice nurse confirmed that GPs did not carry controlled drugs in their medical bags. GPs were responsible for their own medicines carried in their bags although the practice nurse ordered these for GPs on occasions.

Emergency medicines and equipment were stored in the reception area. The practice nurses carried out checks to ensure all medicines were in date and able to be used. We found some indication of these monthly checks however there was no indication of what was checked as there were only signatures against each month. The checklist listed the emergency medicines and equipment. This included oxygen and an Automatic External Defibrillator (AED).

A receptionist explained the practice system for dealing with repeat prescriptions. The patient record system would flag up on the patient's record if they needed to see a GP about their repeat prescription. The patient would be told to make appointment to see a GP. We were also told any prescriptions not collected were reviewed each month although there were plans for this to be done weekly. This would ensure a timely manner to check why patients had not collected their prescriptions.

Repeat prescriptions were the responsibility of individual GPs. The practice had a procedure to manage repeat prescriptions when GPs were absence to ensure these were distributed equally amongst all the working GPs on a daily

Are services safe?

basis. There was not a clear understanding between different staff teams about this pathway. This could compromise patients with repeat prescriptions for medicines requiring review because these may be missed or delayed if the patient's GP was absent.

Cleanliness and infection control

The practice used contract cleaners. During our inspection visit we observed areas were generally clean. We saw the cleaning specification which detailed the level and frequency of cleaning in specified areas of the practice. We saw the daily cleaning checklist used for 2013. The contract cleaners had completed a self-audit form. These audits could be scored but those we looked at had not been scored. There were some comments contained in the audits in relation to areas for improvement and focus.

The reception staff were responsible for dealing with any accidents involving spillage of bodily fluids in the waiting area. The practice manager and reception staff knew where to find the practice infection control policy however they confirmed they had not received any infection control training. The reception staff said they had been told about how to handle any samples given in at reception and showed us where the spillage kit equipment was kept if they had to clean up after anyone who had been unwell.

One health care assistant had received infection control training in a previous job. Both healthcare assistants said they had received a one to one session regarding infection control procedures within the past 12 months. This covered policies, protocols and the use of sharps bins. They both said they felt they had enough infection control knowledge for their respective roles. They described how they would report issues of cleanliness at the practice using a communication book. This book was mainly used for basic communication and issues about environmental issues to be aware of and where various items were stored.

The practice nurses told us various infection control updates, for example, hand hygiene, were provided at nurse team meetings. We also saw hand-washing information displayed around the practice. The treatment rooms had washable floor and wall surfaces. All three treatment rooms had disposable curtains for use around the examination couches. These were replaced annually or if they were badly soiled.

We found that all the staff, clinicians and the cleaners who worked at the practice were vaccinated against Hepatitis B. This promoted the safety of the patients using the practice.

We found lids had not been replaced on tubes of lubricating jelly and there was nothing to indicate when the seals were broken to open the tubes. It is at this point the tube is no longer sterile. We found an open box of sterile neurological examination pins with an expiry date of 2011-07. Patient safety was compromised by the lack of attention to infection control risks.

Staffing and recruitment

Patients were cared for by suitably qualified, skilled and experienced clinicians because checks had been that GPs were included on the performers list, which showed their fitness to practise. Also there were checks of clinicians' registrations with the General Medical Council and the Nursing and Midwifery Council to ensure they were up to date and had not expired.

We found full and relevant checks required for all staff prior to commencing work in the practice had been completed for staff recruited in the last six months prior to this inspection. For example requesting written references and or recording verbal references obtained by telephone or in person. The practice manager said in most cases prospective staff were also already known to the practice.

The practice offered a chaperone service. A chaperone is a member of staff who acts as a witness for a clinician and a patient during a medical examination or treatment. Usually this was provided by one of the nursing team on the request of a GP or nurse, or if a patient wished to have a chaperone. On rare occasions if a nurse or healthcare assistant was not available reception staff were trained and able to do this. All clinical staff and staff who saw patients on a one to one basis had a criminal records check. The practice manager told us the practice had recently introduced Disclosure and Barring Service (DBS) checks for all new reception staff, contrary to advice from the Local Medical Council (LMC) that criminal record checks were not needed for reception staff. Staff employed in the past five years however may not have been checked. There were no risk assessments in place for staff who had not had a criminal record check. This put patients at risk if reception staff who had not had a criminal records check were used as chaperones.

Are services safe?

Dealing with Emergencies

The practice had a contingency plan in place to deal with emergencies. The written plan included information about how to manage loss of computer systems, telephone systems, failure of services such as gas and electricity and what to do if any staff had an accident or became unwell whilst at work. It also included details of organisations to contact if any of this happened.

Equipment

The practice had systems in place to monitor the safety and effectiveness of equipment. The practice manager confirmed that all portable appliance testing, water safety, fire safety, lift maintenance and other equipment checks had been undertaken with appropriate certification and validation checks in place.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective.

The practice had a system in place to ensure the right skill mix and staffing levels were in place to provide an effective service at all times.

Information about individual patients was shared with other healthcare providers such as the out of hours service, midwives, community nursing teams, and palliative care teams.

Patients were provided with information leaflets about their health needs and to support them in making decisions about their treatment. They were also signposted to relevant agencies and services for advice and support. This supported the continuity of the patient's care and patients could be confident that the practice actively engaged with other service providers to ensure they received effective care.

Our findings

Promoting best practice

Patients received care and treatment according to national guidance including guidelines from the National Institute for Health and Care Excellence (NICE) and best practice professional guidelines. A GP in the practice was the lead person for ensuring policy and updates were shared with the other clinicians.

Other examples included the Mental Capacity Act 2005 (MCA). The MCA is a framework which supports people who need help to make decisions. Clinicians were confident in their knowledge of consent and the importance of the assessment of capacity and the application of the law. Parents or guardians were asked to sign consent for babies. The practice did not have a policy for a minimal age to see a child alone however nurses and GPs were confident they would make a personal judgement of how capacity to make informed decisions applied to individual children. They followed guidance based on Gillick competency. This is a recognised tool to help clinicians assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions.

Management, monitoring and improving outcomes for people

The practice was organised with systems in place to monitor the effectiveness of the service it provided. There was a system in place to formally review and learn from significant events. The practice managed significant events well.

The practice completed clinical audits to ensure patients continued to receive the right care and appropriate treatment to meet their needs. These audits mostly related to specific interests of individual GPs for example, we saw an audit of patients with cancer. The practice looked at outcomes for these patients and what they could do to improve them.

The practice had a procedure to manage pathology results when GPs were absence to ensure these were dealt with by the duty GP on a daily basis. There was not however a clear understanding between different staff teams about this pathway.

Staffing

One member of staff told us they considered they worked with a good team where everyone communicated with

Are services effective?

(for example, treatment is effective)

each other. They also told us the GPs were approachable and did not mind being disturbed with queries or concerns about patients. Other staff we spoke with told us about the support they received and said they enjoyed working at the practice.

We saw current Nursing and Midwifery Council (NMC) registration certificates for nurses were kept on their personnel files. The practice took responsibility to arrange insurance for each of the GPs and these certificates were kept by the practice manager.

The nurse manager told us she was responsible for the annual appraisals of all the nurses and health care assistants, and her appraisal was undertaken by the senior partner. We looked at a sample of staff files including nursing staff and reception staff. We saw the appraisal forms had learning needs identified and what action the individual could take in the coming year to improve their knowledge and skills. We also saw an induction form with tasks signed off as completed for different aspects of the induction and training that had been completed.

The reception manager told us reception staff were matched as much as possible with tasks that met their skills and interests. We saw there was a rota of jobs to keep all staff up to date with a variety of jobs and tasks. The reception manager explained that because all the reception staff undertook all reception and administration tasks, this ensured holidays, sickness and other absence could be covered by the team.

Working with other services

The practice worked with other healthcare providers to ensure patients received effective care. We were given examples of when multidisciplinary meetings would be held when assessing a patient's capacity to give consent and to ensure decisions were made in the patient's best interest. We also saw evidence of good working relationships with the palliative care team. Multi-disciplinary meetings were held monthly. These meetings provided a forum to discuss vulnerable patients, for example older people with dementia, patients who were receiving end of life care, and patients who were at risk of hospital admission. We were told it was also an opportunity for talking about safeguarding issues.

Health, promotion and prevention

In the entrance to the practice there was a "Carers Corner" with leaflets and relevant signposting information. Also in the entrance there was a Chlamydia testing pick up box. Staff told us this was specifically placed here so young people could pick up a testing kit without coming into the practice. There was also a notice board with a variety of health promotion information such as healthy living, safeguarding, and sexual health.

Mothers and babies were seen by the health visitors in regular surgeries. The practice had procedures in place to ensure children were immunised at the appropriate time in line with national guidance. Health checks were provided for patients over 45 years of age. We were told that a smoking cessation clinic had been run at the practice however this had stopped a year ago because the Clinical Commissioning Group (CCG) stopped funding.

Are services caring?

Summary of findings

The practice was caring.

All the patients we spoke with and the comments we received were complimentary of the care and service staff provided. They told us they were involved in decisions about their care and treatment and were provided with information to help in making these decisions. Patients were referred appropriately to other support and treatment services. The out of hours service was notified of any pertinent information about individual patients in the event it was contacted by or about the patient. There were opportunities for people to provide feedback about the care and treatment they had received. Patient confidentiality was respected and maintained.

Our findings

Respect, dignity, compassion and empathy

The patients we spoke with told us they were treated with respect. They told us the reception area was discreet so patients did not feel they were overheard and their privacy was respected. The reception staff told us they generally knew which patients had a visual impairment and any written information was provided in large print. They also told us patients could request this form of information. The practice did not have a hearing loop however the staff we asked said they managed and did not need one.

The practice had made an effort to ensure that all areas were accessible to all patients. There was ramped access to the practice with a handrail although the car park had an incline downwards to the entrance. Inside the practice all areas for patients were on the ground floor with easy access for people using wheelchairs or with babies in prams or buggies.

We did not meet or speak with anyone whose first language was not English. Reception staff said there was a telephone language line to use should this be required.

We found reception staff were observant about patients and noted changes in their health and mental well-being. For example if a patient started forgetting they had collected their repeat prescription, the receptionists would inform the patient's GP. They told us living within a close community was useful because they knew most of the patients.

Patients attending an appointment with a contagious condition such as chicken pox were discreetly asked to wait either in the foyer to the practice or a small waiting area to the side of the reception area.

Involvement in decisions and consent

The GPs had their own patient lists. Patients liked this because it offered them continuity of care. Patients knew they may see another GP if they needed an urgent appointment.

The feedback we received about patients experience of their healthcare was positive about the GPs and nurses. One patient told us they had been offered an injection and also given written information about the injection. Another patient told us their medicine was explained to them. Generally patients told us the GPs spoke to them in a way

Are services caring?

they could understand but without being patronising. They also printed information from the internet, gave a website address or provided a leaflet so patients could go away and read more about their condition and or treatment.

Practice staff cared for patients with long term conditions including asthma, diabetes, and heart disease. They provided child immunisation, travel vaccinations and phlebotomy (the process of taking blood) services. Maternity services were provided by the GPs and the locality midwifery teams. We saw examples of how consent was obtained and recorded in patient records. We saw systems were in place to make sure urgent and routine referral letters were triaged, written and sent promptly. Patients were able to telephone to find out about a referral or test results.

We saw in staff files everyone working at the practice had signed a confidentiality agreement as part of their contract of work. All staff also underwent training about information governance (sharing confidential information).

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients needs.

Patients individual needs were met without avoidable delay.

The practice recognised the need to provide a flexible service to meet the needs of patients with caring responsibilities.

There was an open culture within the practice with a complaints and feedback system in place. The practice learned from the experiences, concerns and complaints of patients and made changes to improve the quality of care it provided.

Our findings

Responding to and meeting people's needs

Patients spoke positively about the clinical care they received from the GPs and nurses. They told us they felt they were involved in their care and treatment. They confirmed they had time to think about the treatment options and felt able to ask questions if they were unsure about anything. Patients said they were offered additional information about their illness.

The practice had a Carers lead person who was responsible for signposting and monitoring patients who had responsibility for providing full time care to a dependent. New patients were asked at registration if they had any caring responsibilities. If so, these were recorded on their patient record. At the time of our visit the practice had identified 154 patients who were carers. This was 2% of the practice patient population. Carers were sent an information pack with direct contact details for different services and information leaflets. In their patient record, carers were shown as a vulnerable person in order to flag that their appointment should accommodate their needs as for example, they may not be able to leave someone alone.

The practice rarely used locum GPs as they were able to work flexibly around their part hours and cover each other for periods of sickness, annual leave and other absence. Nurses also covered themselves for periods of leave and sickness. We found there had been a period when the practice was very short staffed over a Christmas period. This was an issue over the booking of holidays but had been resolved with changes in the system for booking leave.

The practice had a contingency plan in the event of any sort of disruption to the service it provided. This was put into action and the policy followed in 2013 when part of the practice roof had collapsed. We also saw the practice had put together a separate contingency plan during the Olympics when the sailing events were held in Weymouth and there was the potential for an increase in demand by visitors to the area.

Access to the service

Patients told us if they needed to see a GP urgently they would be seen the same day although this may not be with their preferred GP. We saw a notice in the waiting room

Are services responsive to people's needs?

(for example, to feedback?)

advising patients they could book routine appointments up to eight weeks in advance. Patients told us it was about a two week wait for a routine appointment. One patient told us it was better to call on the day and avoid waiting.

Appointment slots were for ten minutes unless the GP or nurse had indicated a longer appointment needed to be booked. Patients told us there tended to be a wait after their due appointment time although this was not usually very long, and between five to ten minutes. One patient said the longest they had ever waited was 45 minutes however this was very unusual.

The majority of the patients we spoke with complained about the difficulty they had getting through on the telephone to make an appointment. They also said they had to call in the morning at 8.30am but appointments were usually all gone by 8.40am. The practice manager told us and we observed five direct lines were allocated to staff to answer telephones between 8.30 and 9am. This was to ease the length of time people were kept waiting on hold. We saw most patients were offered an appointment within two days. For patients wishing to be seen on the same day and if no appointments were available, they were invited to sit and wait to see a GP at the end of surgery. Patients accepting this were advised that their time slot would be for five minutes and for urgent reasons only.

Two patients commented about the opening times of the practice. One patient said they would like to have the option of earlier morning appointments or longer opening hours. The other patient seemed satisfied they could book evening appointments.

One patient told us they had a named GP. Another patient said they had been allocated a named GP when they registered with the practice. They also said they could have changed if they preferred a different GP.

Most referrals were made via the choose and book option. For patients with a learning disability and older patients, the practice staff offered to assist with this. Referrals to mental health services went directly to the service from the GP.

Concerns and complaints

The majority of complaints were about appointments and the practice car park. The patients we spoke with did not know how to make a complaint however they told us they would speak with a member of staff or their GP. One patient told us they would put a complaint in writing if they had one. Another patient told us they had raised a query rather than a direct complaint. They said this had been treated as a complaint by a GP and they were satisfied with an appropriate outcome.

We saw the practice website had a form patients could download and complete to raise a complaint. They could also telephone, email or ask at reception about making a complaint. We saw a policy for complaints, a notice in the waiting room and a practice leaflet about how to make a complaint that patients could take away with them. The practice manager told us this leaflet was updated annually. Any complaints received were passed to the practice manager. If the complaint was about a clinical matter, these were passed to a GP with lead responsibility for this. A response was sent to the complainant within three days and included an estimated time scale for a full response. Subsequent letters were sent if needed to keep the complainant up to date about the progress of the complaint. Patients were always invited in to discuss the issue. Every clinical complaint was discussed at the clinical update meeting held monthly for all clinical staff. The practice informed the patient of any learning which had come from their complaint. All clinical staff received a copy of the minutes. We saw, for example, how procedures had been changed as a consequence of a patient being unhappy with a clinical method used at the practice. This new procedure was sent to the patient to show how they had been listened to and that action had been taken as a consequence.

Are services well-led?

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

Summary of findings

The practice was well-led.

There were organisational structures in place with clear lines of accountability and responsibility. The staff we spoke with were clear about their role and responsibilities. The leadership within the organisation held itself and others to account for the delivery of an effective service. The practice promoted an open and fair culture.

The practice offered a service that was of good quality through clinical governance and systems in place to provide on-going monitoring. There were aspects of safety that were compromised.

Staff and clinicians received an annual appraisal to discuss their performance and issues relating to their role. Regular meetings were held where staff were encouraged to contribute their ideas, suggestions and concerns.

Our findings

Leadership and culture

Staff told us they worked within a friendly, supportive atmosphere. Staff meetings were held quarterly and staff could raise issues and make suggestions about ways to improve the service they offered. The staff said they knew they would be listened to and they felt valued which enabled them to feel able to contribute to these meetings. All staff were clear about their roles and responsibilities, and they were provided with opportunities for development and training. Staff appraisals were carried out annually and training was supported by the GP partners and practice manager.

The GPs had overall leadership of the practice but delegated day to day responsibility to the practice manager. The senior partner met with the practice manager weekly for an update and overview of the practice. This enabled the practice manager to have delegated responsibility without needing to address every issue at the partners meetings. The nurse manager met with the GPs twice a month for clinical updates and also worked closely with the practice manager.

As a consequence of administration and reception staff raising concerns about poor communication between clinicians and their teams, a weekly briefing was introduced for all the team managers. Information about any proposals of changes from practice meetings and partners meetings was passed on at these meetings. No changes to practice procedures or protocols were made until these managers knew and had made their teams aware of the proposed changes. The practice manager told us they had recognised communication was a problem that needed to be addressed, and the weekly meeting was working towards improvement.

Governance arrangements

The practice worked to the Quality and Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. The QOF contains groups of indicators, against which practices score points according to their level of achievement in relation to enhancing the quality of life for people with long term conditions. For example, the

Are services well-led?

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

percentage of patients with coronary heart disease whose blood pressure readings were acceptable. We found the practice performed well with QOF in 2012/13 and 2013/14 with similar results both years.

The GPs had lead roles such as safeguarding or QOF, so it was clear who had responsibility for making specific decisions and monitoring the effectiveness of specific areas of clinical practice. There were a number of different teams set up within the practice and it appeared the GPs relied on the practice manager overseeing these teams for the day to day running of the service and assessing, monitoring and developing non clinical staff.

Systems to monitor and improve quality and improvement

The practice undertook a number of audits. We saw examples where protocols and procedures were changed as part of learning outcomes from incidents and audits. We saw incidents and complaints were monitored and used as part of training and learning sessions.

Patient experience and involvement

The practice was in the early stages of developing a Patient Participation Group (PPG). Feedback we received from this group indicated the practice manager was working with the group to design a strategy to make the patient voice heard. We were told communication was dependent on patients having access to and using email. They were exploring other methods in order to reach a wider range of patients.

The practice had surveyed a random selection of patients about extended opening hours but it had not undertaken any other in-house patient survey.

Staff engagement and involvement

The staff we spoke with were all positive about working at the practice. They enjoyed their jobs and said they were supported to raise issues and concerns by a culture of openness and feeling valued.

Learning and improvement

We saw on staff files and staff told us they had annual appraisals. These appraisals identified training needs and how these could be met. Nursing staff files contained evidence of professional training and personal development. GPs had protected learning time to ensure they were aware of current research and best practice guidance. They maintained a record of evidence to showed details of the continual professional development which included study days and individual learning. Their appraisal included quality improvement actions where the GP demonstrated their input into the profession and discussion of any significant events, feedback from patients and colleagues and looking at any complaints.

All staff received training about basic life support and the treatment of shock annually. They also attended fire safety awareness training and safeguarding training. All staff were signed up to and understood the legal requirements they had to meet in order to comply with the Data Protection Act 1998.

Identification and management of risk

The practice had a contingency plan and a copy of telephone numbers and contacts was held in the reception area for ease of access. The practice had identified a risk of staff shortages during popular holiday periods and had put in place a different system for booking annual leave to mitigate against the likelihood of this recurring.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Treatment of disease, disorder or injury	**Health and Social Care Act 2008 (Regulated Activities) Regulations 2010** **Regulation 21: Requirements relating to workers.** The registered person must – (1) (a) Operate effective recruitment procedures in order to ensure that no person is employed for the purposes of carrying on a regulated activity unless that person - is of good character Risk assessments were not in place for roles that were considered by the practice to not require a criminal record check.