The Bridport Medical Centre 1

Quality Report

The Bridport Medical Centre, West Allington
Bridport, Dorset, DT6 5BN
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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 The Bridport Medical Centre on 26th May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe,well-led, effective, caring and responsive services.

The practice is also rated as good for the six population groups which 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 and people experiencing poor mental health (including people with dementia).

Our key findings across all the areas we inspected were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance.
- Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management.
- The practice proactively sought feedback from staff and patients, which it acted on.

We saw one area of outstanding practice:

- The practice operate a virtual ward system. This is a comprehensive, fully integrated service for all vulnerable patients in the Bridport area with a particular focus on older patients. This system includes weekly meetings with senior multi-disciplinary team professionals, including a community elderly care consultant, a consultant elderly care psychiatrist, Social Services, District Nursing, Mental Health and Community Matron colleagues. This virtual ward supports early hospital discharge or allows seamless admission to Bridport Community Hospital with integrated care when necessary.

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

Importantly the provider should:

- Ensure holding letters for complaints are sent out according to the practice policy and that all correspondence is dated.

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 and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed.

There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services.

Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely.

Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health.

Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Staff worked with multidisciplinary teams.

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. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.

Information for patients about the services available was easy to understand and accessible.

We saw that staff treated patients with kindness and respect.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

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

Summary of findings

Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs.

Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this.

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

The practice had policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk.

The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was actively consulted and involved in developing the service provided.

Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people.

The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

- All patients aged over 75 had a named GP
- Home visits for housebound patients were available if needed.
- Invited external agencies to flu clinics, such as fire service, to give advice and information.

People with long term conditions

Good

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

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met.

For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

- A clinical pathways team reviewed long term conditions pathways to improve care and reduce unnecessary appointments.
- An in-house phlebotomy service was available for those who needed blood tests.

Families, children and young people

Good

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

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances.

Summary of findings

There was a priority service for unwell children which ensured they were seen within 24hrs.

Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.

Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

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

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

GP telephone consultations were available for some medication reviews, results and advice.

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

All patients on the learning disability register had an annual review and health check.

Weekly prescriptions were available for patients who were at risk of over using medications

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

100% of people experiencing poor mental health had received an invitation for an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with five patients on the day of our inspection. All of them were very positive about their experiences of care and treatment at the practice.

All the patients we spoke with told us that their treatment was clearly explained to them and they were able to ask questions and make choices about their treatment or medicine. Patients said they felt there were enough staff and the staff had the right skills and experience to meet their needs. They also told us they had enough time with the GP or nurse to discuss their concerns.

We received five comment cards on the day of our inspection. All the comments told us that the practice was caring and compassionate.

We reviewed data from the national patient survey which showed the practice was rated above the national average by patients who were asked if they were given enough time during their appointment by clinicians and their confidence and trust in the last nurse they saw. 95% of respondents described their overall experience of this practice as good and 90% of patients surveyed were able to get an appointment to see or speak to someone the last time they tried.

Areas for improvement

Action the service SHOULD take to improve
The practice should take the following action to improve the service provided:

- Ensure holding letters for complaints are sent out according to the practice policy and that all correspondence is dated.

Outstanding practice

We saw one area of outstanding practice:

- The practice operate a virtual ward system. This is a comprehensive, fully integrated service for all vulnerable patients in the Bridport area with a particular focus on older patients. This system includes weekly meetings with senior multi-disciplinary team professionals, including a community elderly care consultant, a consultant elderly care psychiatrist, Social Services, District Nursing, Mental Health and Community Matron colleagues. This virtual ward supports early hospital discharge or allows seamless admission to Bridport Community Hospital with integrated care when necessary.

The Bridport Medical Centre 1

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included another CQC inspector, a GP specialist advisor and a practice manager specialist advisor.

Background to The Bridport Medical Centre 1

Bridport Medical Centre is a large rural practice serving the health needs of approximately 18,000 patients.

The practice team consists of 10 GP partners who together work an equivalent of eight and a quarter full time staff, three nurse practitioners, six practice nurses and three health care assistants.

The practice is a registered training practice. This means that GP Registrars are placed at the practice as part of their training and supervision before becoming fully qualified GP's.

Three GP partners are actively engaged at locality level. One GP is the locality chair, one is the deputy chair and another partner is the locality prescribing lead.

GPs and nursing staff are supported by an administration and reception team and the practice manager.

The practice is located at West Allington, Bridport, Dorset, DT6 5BN.

The opening hours are Monday to Friday 830am to 630pm. Extended hours opening is available from Monday to Thursday between 630pm and 715pm. The practice is open on the second Saturday of each month. These are for routine, pre-bookable appointments only.

Out of hours services are provided for patients by using the NHS 111 service.

There are designated disabled parking bays opposite the practice entrance together with drop-off points. There is level access to the building. The surgery has wide doors to allow for wheelchair access and there is good access to all of the consultation rooms. Accessible toilets are available throughout the building and there are lifts to first floor services. Wheelchairs are available for use if required and a hearing loop system is available at the reception desk. The practice has an easy read practice leaflet for patients with learning disabilities. This was developed with Dorset People First.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew about the practice. Organisations included the local Healthwatch, NHS England, and the clinical commissioning group.

We asked the practice to send us some information before the inspection took place to enable us to prioritise our areas for inspection. This information included; practice policies, procedures and some audits. We also reviewed the practice website and looked at information posted on NHS Choices.

During our visit we spoke with a range of staff which included GPs, nursing and other clinical staff, receptionists, administrators, secretaries and the practice manager. We also spoke with five patients who used the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the practice before and during our visit.

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 include:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- 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, such as 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 patients activating the emergency switch in the patients toilets.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We reviewed records of nine significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held every three months to review actions from past significant events and complaints or sooner if required. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

One example we saw was a responsive investigation into a dosage error. The practice received and reviewed the evidence and created an action plan to resolve the issue and prevent a similar incident from happening again. Appropriate actions were taken to ensure patients were safe and learning sheets were completed and updated.

Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated to practice staff at monthly meetings or when needed if the actions required were urgent. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed at practice and partner meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. This included level three for GPs and level two for nursing staff. We asked members of medical, nursing and administrative staff about their most recent training. They told us the training was completed on line and also face to face on an annual basis. Training records we examined also confirmed this.

The practice had appointed a named GP as its lead in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil this role. All staff we spoke with were aware who this lead was and who else to speak with in the practice if they had a safeguarding concern and the lead was unavailable.

There were appropriate policies for safeguarding vulnerable adults and children. These had been reviewed in May 2015. All of the staff we spoke with knew the location of the policies and were familiar with their contents.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. These contact details were available at reception and in each consulting room.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to

child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Vulnerable adults and children were discussed at monthly multidisciplinary team (MDT) meetings and significant event meetings every three months. The practice also held regular meetings with the local adult social services team. Staff gave one example where they held discussions to try and find suitable accommodation for a local homeless person. We also saw evidence the practice had joint working arrangements with health visitors and school nursing teams to share information regarding any children that may be at risk.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms and on the practice web site. It was also clearly explained in the practice leaflet. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). If a chaperone had been used then the name of the chaperone was recorded on the patient's notes.

All nursing staff, including health care assistants, had been trained to be a chaperone. Non-clinical staff would also act as a chaperone if nursing staff were not available. These staff members had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. Staff explained the training was a mix of online and in house verification of skills, knowledge and understanding of the role. All of the staff we spoke with were familiar with the chaperone policy that had been reviewed and updated in November 2014.

All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

The practice had a policy for whistleblowing that had been reviewed in May 2015. All of the staff we spoke with were aware of the circumstances in which they may wish to raise a concern. There was a designated lead for whistleblowing in the practice. Staff were also aware they could report any concerns to other people within the practice or outside agencies.

All staff had received training on information governance. This training was completed on line and staff were given protected time to do this. There was a named Caldicott guardian at the practice. All of the staff we spoke with were aware of the importance of keeping information around patient records safe and secure. We observed good practice of staff logging off when leaving computers unattended. Patient records were stored on a computer system and on paper. The paper records were stored in an archive room that was kept locked and secured when not in use. The information on the computer system was backed up on a server away from the premises.

Cleaning staff had signed confidentiality agreements as they may see confidential information. The practice was also currently registered with the information governance office. This means the practice has signed an agreement to state they will comply with the requirements set out in the Data Protection Act.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. All of the staff we spoke with were aware of the procedures to follow in the event of a break in the cold chain. Records showed refrigerator temperature checks were carried out and recorded on a daily basis, when the practice was open, to ensure medication was stored at the appropriate temperature.

All three medicine refrigerators at the practice had their own thermometers and log books. They were tested and calibrated to ensure they were working correctly on an annual basis. The last test was carried out in May 2015. Calibration is where measuring equipment is checked to ensure it is accurate.

Good

Are services safe?

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. For example, we saw that all prescription pads were kept in a locked cupboard and individual serial numbers were recorded in and out for each prescriber.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We also saw that a recent clinical audit cycle of the prescribing of antibiotics had been completed.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. Controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. All controlled drugs were recorded, administered and disposed of in line with national guidelines. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used up to date Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

Cleanliness and infection control

We observed the premises to be visibly clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment (PPE) including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had reviewed their policies at the beginning of May 2015. These policies included a hand washing policy, PPE policy as well as the main infection control policy. The practice had also completed an annual infection control statement and an infection control audit and checklist in May 2015.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, hand cleansing gel and paper hand towel dispensers were available in treatment rooms. Hand cleansing gel dispensers were available throughout the practice including the reception and waiting room.

Staff explained and demonstrated the processes for handling specimens brought in by patients.

Spillage kits for mercury, blood and bodily fluids were available and all of the staff we spoke with knew where these were located. A control of substances hazardous to health (COSHH) record was kept at the practice. This record explained how to handle individual substances that had the potential to cause harm.

Good

Are services safe?

Clinical waste was stored and disposed of in line with the clinical waste regulations. There was a named lead for clinical waste and the practice policy for the handling of clinical waste was reviewed and updated on an annual basis with the last review in December 2014. All of the clinical staff we spoke with were knowledgeable on the safe handling, storage and disposal of clinical waste including sharp instruments and boxes. Waste consignment notes were kept for three years.

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records that confirmed the practice was carrying out regular monthly checks in line with this policy to reduce the risk of infection to staff and patients. A legionella risk assessment was carried out in March 2015.

The practice was cleaned daily by an external cleaning company. Daily cleaning logs were kept and there was a monthly cleaning audit. The cleaning company were responsible for cleaning the blood pressure machine in the waiting room. Records showed that curtains in treatment rooms were changed every six months.

Equipment

Staff we spoke with told us they had enough suitable equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was February 2015. A schedule of testing was in place. We saw calibration of relevant medical equipment took place on an annual basis. This included weighing scales, spirometers, blood pressure measuring devices and the refrigerator thermometers.

There were processes in place for staff to report faulty equipment. The staff we spoke with explained how they would log and report faulty equipment.

We noticed that the blood pressure machine for use by patients in the waiting area was showing an incorrect time. The clock had not been moved forward one hour to account for British summertime. Records showed this had been calibrated in January 2015. Although staff told us they regularly checked the machine there were no records of this. The cleaning company who were responsible for cleaning this piece of equipment had also not recorded the clock was incorrect.

Staffing and recruitment

The practice had a recruitment policy, reviewed in May 2015, that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at four recruitment records and all of them contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Newly appointed staff had this expectation written in their contracts.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

The practice explained that one of the GPs was to retire in 2016. A replacement GP has already been recruited to take over and there will be a three month handover to ensure a smooth transition for staff and patients.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment.

Good

Are services safe?

The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. A health and safety risk assessment had been completed in February 2015. Any risks that were identified had an action plan and a date when the actions were completed

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this where a GP was to retire and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

The practice had procedures in place for dealing with any abusive patients. Staff knew how to report any incidents to the practice manager. Records showed that any incidents were appropriately dealt with.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. There were also two trained first aiders at the practice, as well as nurses and GPs.

Emergency equipment was available including access to oxygen and an automated external defibrillator (a portable electronic device that analyses life threatening irregularities of the heart including ventricular fibrillation and is able to deliver an electrical shock to attempt to restore a normal heart rhythm). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a collapsed patient and that the practice had responded to this incident whilst protecting the patients dignity.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in May 2015.

The practice also had a buddy system with Bridport community hospital. This was where patients would be able to be seen if for some reason the practice was unable to be opened to the public. All GPs and the practice manager had a hard copy of the business continuity plan.

The practice carried out a fire risk assessment in 2014 that included actions required to maintain fire safety. The fire alarm was tested weekly and fire exits were clearly signed and free of obstructions. The practice had a fire rucksack at reception. This rucksack contained high visibility jackets, the fire protocol and roll call documentation as well as hand held communication devices. Staff had received annual fire training and were aware of their responsibilities. The staff explained how they carried out an evacuation of the building in October 2014. Regular fire drills also took place.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. The practice also offers GP with special interest clinics including ophthalmology and dermatology.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met. Any unplanned admissions to hospital were discussed and talked through with the nursing team and GPs.

National recommendations suggest that care plans should be in place for 2% of the at risk and vulnerable patients. We saw evidence the practice was doing this for 3% to 6% of its patients in this group.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. All staff had completed on line anti-discrimination training.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us four clinical audits that had been undertaken in the last three years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. Following each clinical audit, changes to treatment or care were made where needed and the audit repeated to ensure outcomes for patients had improved. For example, the antibiotic audit showed that reduced prescribing and increased effectiveness had taken place. The aim of the audit was to ensure that all prescribed antibiotics were necessary and in line with local guidelines. The audit had been repeated on an annual basis over the previous four years.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a

Good

Are services effective?

(for example, treatment is effective)

result of information from the quality and outcomes framework (QOF). (QOF 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 and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and non-steroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 96.7% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

- The percentage of patients with diabetes, on the register, who have had an influenza immunisation in the preceding 12 months was 99.69% which was above the national average of 93.49%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average at 83%.
- Performance for mental health related QOF indicators was similar to the national average.

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed. For example the percentage of women aged 25 or over and who have not attained the age of 65 whose notes record that a cervical screening test has been performed in the preceding five years was 76%, which was below the national average of 81%. The practice has a higher than national average of older people which explains this discrepancy. However, the practice are proactively encouraging women to attend screening tests by the use of posters, information and speaking with them at appointments.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year. Staff records we looked at confirmed this was being done.

The practice's prescribing rates were also similar to national figures and there was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check the patients receiving repeat prescriptions had been reviewed by a GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used.

The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. There was a named GP lead for end of life care. Patients we spoke with told us their relatives had care plans in place to meet their end of life wishes. It was explained that patients, care homes, family members and the practice are all involved in end of life care discussions.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such homeless, travellers and patients with learning disabilities.

Structured annual reviews were undertaken for people with long term conditions such as Diabetes, chronic obstructive pulmonary disease (COPD) and Asthma. These reviews were led by designated GP leads with specialist qualifications.

Effective staffing

Practice staff included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with all of them having additional diplomas in areas such as sexual and reproductive medicine, diabetes, chronic heart disease and stroke. All GPs were up to date with their yearly continuing

Good

Are services effective?

(for example, treatment is effective)

professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff had annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and relevant courses, such as phlebotomy and immunisations. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and carrying out extended roles such as seeing patients with long-term conditions including asthma, COPD, diabetes and coronary heart disease.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising these communications. Out-of hours reports, 111 reports and pathology results were all seen and acted on by a GP on the day they were received.

Discharge summaries and letters from outpatients were usually seen and reviewed on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings on a weekly basis to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

The practice had also signed up to the electronic Summary Care Record and this was fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). Patients were able to opt out of this scheme if they wished.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

There was a range of printed material available for patients in a dedicated information zone. This information included

Good

Are services effective?

(for example, treatment is effective)

practice specific leaflets such as complaints, minor surgery, diabetes and advanced directives (also known as living wills). There was also community information that promoted services for carers, eating disorder and mental health and wellbeing services. A small talk newsletter was available which was a guide to local pregnancy, baby and toddler services for parents.

The practice used the information zone to provide information to patients about the practice performance. This included the results of the patients survey, friends and family test and comments received. Patients were also made aware of what the practice was doing to improve services for patients. This information was presented by a practice newsletter and practice charter for patients.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent. We saw examples of written consent where coils and other contraceptive implants had been fitted

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice's performance for the cervical screening programme was 76%, which was below the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 71%, and at risk groups 42%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 92% to 97% and five year olds from 91% to 97%. These were comparable to CCG averages.

The practice undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices and were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015 and a survey of 593 patients undertaken by the practice's patient participation group (PPG) in 2014. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed that 95% of respondents described their overall experience of this surgery as good. Other results were as follows:

- 88% said the GP was good at listening to them compared to the CCG average of 89% and national average of 87%.
- 86% said the GP gave them enough time compared to the CCG average of 88% and national average of 85%.
- 94% said they had confidence and trust in the last GP they saw compared to the CCG average of 93.9% and national average of 92%

Patients completed CQC comment cards to tell us what they thought about the practice. We received five completed cards and four were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. One comment was less positive and told us they did not have enough time with the GP. We also spoke with five patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all 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 and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. However, we noticed that information was easily overheard due to the design of the building. The practice were aware of this and had put measures in place to try to prevent this. Examples of these were a system to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled some confidentiality to be maintained. There was also the use of a room opposite the reception area if this was needed.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 87.4% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84.1% and national average of 82%.
- 79% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 74%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

A Hearing loop was in place at reception This was also portable and could be moved to the consultation rooms if needed. The practice had electronic booking in system so patients did not have to go to reception. We noticed several patients either did not see the system or elected not to use it. Reception staff were more than happy to book them in for their appointment at reception.

The practice operate a virtual ward system. This is a comprehensive, fully integrated service for all vulnerable patients in the Bridport area with a particular focus on older patients. This system includes weekly meetings with senior multi-disciplinary team professionals, including a community elderly care consultant, a consultant elderly care psychiatrist, Social Services, District Nursing, Mental Health and Community Matron colleagues. The aim of the virtual ward is for all team members to help attain the best care for patients by avoiding professional boundaries and budgetary constraints. This virtual ward supports early hospital discharge or allows seamless admission to Bridport Community Hospital with integrated care when necessary. The virtual ward aims to reduce unplanned or inappropriate admissions and facilitates home care wherever possible. End of life patients are discussed at the gold standards framework meetings but this merges seamlessly with the virtual ward.

Immunisation campaigns took place, for example influenza and shingles, at the practice and in local rural village halls. The practice invited external agencies to also attend. An example of this was a fire safety advisor from the local fire service to give fire prevention advice.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 84% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 83%.
- 81% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 79y% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and by giving them advice on how to find a support service. Patients we spoke with who had a bereavement confirmed they had received this type of support and said they had found it helpful.

patient information leaflets were available for carers and for those who had suffered a bereavement. counselling services were also advertised.

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 patient's 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.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). This included putting a water dispenser in the waiting area.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. Other examples were services for holiday makers and temporary residents and homeless people. The majority of the practice population were English speaking patients but access to online and telephone translation services was available if required. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with limited mobility. The consulting rooms were also accessible for patients with limited mobility and there were access enabled toilets and baby changing facilities. We witnessed an incident where the emergency cord was pulled in the patient toilet. Staff were very quick to respond and dealt appropriately with the incident that turned out to be false alarm.

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.

Patients were notified the GP was ready for them by a loud audible sound and through a message displayed on the television screens. The text on the screens was clear, easy to read and in a large font. Patients waiting to see a nurse were met by the nurse in the reception and taken to the treatment rooms which all had height adjustable couches.

Staff told us that they had some patients who were of "no fixed abode" and they would see someone if they came to the practice asking to be seen. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor. We examined the rota and found there was always a male and female GP on duty.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 830am to 630pm Monday to Friday. Extended hours appointments were available every evening Monday to Thursday between 630pm and 715pm, and on the second Saturday of each month. These were for routine, pre-bookable appointments only.

Patients were able to book routine appointments with their preferred GP up to six weeks in advance. They were able to see any GP within 48 hours or be seen on the same day if it was an urgent matter. Appointments were able to be booked in person, on the phone or on line.

GP telephone consultations for some medication reviews, results and advice were available to those who were at work or were unable to physically attend the practice.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients in the patient leaflet and on line but this information was not displayed outside the practice.

There was an easy read practice leaflet for patients who had learning disabilities. This had been developed with Dorset people first.

Other online services for patients enabled them to order repeat prescriptions, book and cancel routine appointments, view their patient summary record and complete and submit forms.

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Services available for patients at the practice included chronic disease management, phlebotomy, blood pressure checks, adult and child vaccinations and immunisations, cervical screening, health checks and minor surgery and injections.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 80.5% were satisfied with the practice's opening hours compared to the CCG average of 77.8% and national average of 75%.
- 83.7% described their experience of making an appointment as good compared to the CCG average of 82% and national average of 74%.
- 70.8% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67.8% and national average of 65%.
- 73% said they could get through easily to the surgery by phone compared to the CCG average of 81.7% and national average of 71.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

The practice has introduced new systems in order to improve telephone access as a result of the patient survey results.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were reviewed and updated in May 2015 and were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Posters were displayed around the practice, information was available on the web site and in the practice leaflet. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints out of the 11 received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and apologies made where appropriate. The records showed openness and transparency with dealing with the complaint and that there was no common theme to complaints received.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and although no themes had been identified, lessons were learned from individual complaints and improvements made to the quality of care as a result. We saw an example where a patient wished to complain about their electronic prescription being sent to the wrong pharmacy. We observed how a member of staff took charge and did everything possible for the patient to get their prescription sorted out. The staff member continuously reassured the patient and explained what had happed.The patient thanked the member of staff. The practice became aware of an issue surrounding the newly implemented electronic prescription service and took steps to prevent similar incidents from happening.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We found that the practice did not always send complaint holding letters with the complaints leaflet and details of advocacy services within three days and correspondence was not always dated.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice.

The aims of the practice were clearly available to patients through the practice charter. This set out the philosophy of the practice.

The practice has implemented plans to develop closer links with other local practices with an aim to federate in 2015.

The practice is also in the process of developing and implementing a priority service for a team approach to care.

The practice is an accredited GP training practice and continues to learn through training future GPs. The practice has plans in place to develop as "centre of excellence" by attracting trainees and future GP placements.

Three GP partners are actively engaged at locality level. One GP is the locality chair, one is the deputy chair and another partner is the locality prescribing lead.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at all of these policies and procedures and they had been reviewed annually and were up to date.

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 there was a GP who was the lead for safeguarding. All members of staff we spoke with were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance. The QOF data for this practice showed it was performing above the national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. This included opening hours and putting a water dispenser in the waiting area. The practice regularly submitted governance and performance data to the clinical commissioning group.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example health and safety and infection control. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment, induction policy, management of sickness, which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always take 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.

Are services well-led?

Good

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

We saw from minutes that team meetings were held every week. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported in the practice.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from all of the population groups. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

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. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that annual appraisals took place which identified personal development. Staff told us that the practice was very supportive of training and that they had protected learning time.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.