Stalbridge Surgery

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stalbridge Surgery on 15 March 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had safe and effective systems for the management and dispensing of medicines, which kept patients safe.
- Feedback from patients who use the service, those who are close to them and stakeholders was continually positive about the way staff treat people. Patients told us that that staff go the extra mile and the care they receive exceeds their expectations.
- There is a strong, visible, person-centred culture. Staff are highly motivated and inspired to offer care that is kind and promotes people's dignity. Relationships between patients who use the service, those close to them and staff are strong, caring and supportive.These relationships are highly valued by all staff and promoted by leaders.
- Staff recognise and respect the totality of people's needs. They always take patients personal, cultural, social and religious needs into account.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with the GP and that there was continuity of care, with 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.
- The provider was aware of and complied with the requirements of the Duty of Candour

We saw several areas of outstanding practice:

- The culture of the practice focused on community engagement and being central to community life. Patients benefited from this emotional and physical well-being support
- The practice had a thorough system in place to support bereavement through staff support, bereavement packs and their own bereavement cards.
- The practice nurses performed complex leg ulcer dressings in the practice and also worked with the dermatology department at the local acute trust following extended additional training avoiding the need for patients to travel for these services.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.
- Recruitment procedures and checks were completed as required to ensure that staff were suitable and competent.
- There were arrangements for the efficient management of medicines.
- The practice was clean, tidy and hygienic. We found that arrangements were in place that ensured the cleanliness of the practice was maintained to a good standard.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework between 2014 and 2015 showed patient outcomes were at or above average for the locality and compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement and were shared with other clinicians and students at the practice.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs. The practice provided extensive support to palliative care patients.

Are services caring?

Good

The practice is rated as good for providing caring services.

Summary of findings

- Data from the National GP Patient Survey showed patients rated the practice highly and was higher or comparable to national averages for example 96.4% patients said they had confidence and trust in the last GP they saw (CCG average 96.6. %, national average 95.2%) 95.53% said the last nurse they spoke to was good at treating them with care and concern (national average 90.58%) and 91% said they found the receptionists at the practice helpful (CCG average 90.4%, national average 86.8%).
- Feedback from patients about their care and treatment was consistently and strongly positive. Patients' comments provided examples of the personal support they received from GPs, for example coping with cancer and at times of bereavement.
- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. Staff were committed and trained to provide good customer care. We found many positive examples to demonstrate patients were consulted about the service provided and their choices and preferences were valued and acted on.
- There were numerous examples of staff members 'going the extra mile' to support patients. particularly in regard of palliative care patients. Each patient was discussed monthly at a dedicated multidisciplinary meeting with representatives from the district nurses and the local hospice. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff 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. For example extended practice hours were offered on Saturday mornings between 9am and 12.30pm.
- Patients said they found it easy to make an appointment with a GP and there was continuity of care, with appointments available the same day.
- The practice interacted with the Patient Participation Group (PPG) and shared information with their members.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs. The practice was accessible to patients with disabilities and staff relocated to the ground floor to see patients when needed.
- Information about how to complain was available in the practice and on the practice website, it was easy to understand and evidence showed that the practice responded quickly to all complaints. Learning from complaints was carried out and 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 to deliver high quality care and promote good outcomes for patients. 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 a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a focus on continuous learning and improvement at all levels.

Summary of findings

The six population groups and what we found

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

Older people

Outstanding ☆

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

The practice offered proactive, personalised care to meet the needs of the older people and had a range of enhanced services. For example, in dementia and end of life care.

The practice was responsive to the needs of older people, and offered home visits and rapid access appointments for those with complex needs. Home visits were routinely made on request for those elderly patients housebound by illness or disability by members of the clinical team. Reception staff assimilated those requests and added them to the 'home visit surgery' that was held as a daily computer session. An electronic message was sent through to the GP outlining the brief collected information on the request. Throughout the morning surgery these were assessed and where indicated a telephone call made to assess the urgency of the request. This may have led to the home visit being upgraded as needing more urgent attention than waiting until the routine lunchtime visit and an appropriate member of the clinical team would visit as soon as possible.

A health care assistant made home visits to undertake a holistic health assessment for those over aged 75 years who were identified as in possible need of further care and support.

All patients receiving regular medicines were seen for regular reviews. The practice was a small practice and the staff knew patients well, and were familiar with their family situations, those who were socially isolated, and those who were carers. This meant that staff recognised when something could be wrong with a patient and be proactive in providing support for that person.

The practice participated in the unplanned admissions enhanced service. Systems were in place to identify the top two percent of the practice population who were judged to be most at risk. Patients were made known to staff and placed on the frailty scheme. GPs held monthly reviews of these patients with a multi-agency team and voluntary organisation to proactively co-ordinate their care, perform medicine reviews and dementia reviews. Systems were in place to ensure patients had prompt access to treatment, regular updates of care plans and treatment escalation plans, which were then shared with out of hour's providers.

The GP at the practice made monthly visits to local care homes. Feedback from both care home managers demonstrated that this

provided continuity of care and responsive palliative care for older people. GPs had developed strong relationships with the residents, managers and staff. They were described as 'fantastic and 'wonderful'.

Practice staff formally discussed 'admission care avoidance' with the multidisciplinary (MDT) community team each month to help maintain patient independence and enabled patients to remain at home, rather than be admitted to hospital. The MDT team were also able to refer patients to other health and social care services. There was a community matron attached to the practice one day a week providing care for the elderly and those with chronic disease in the community.

The systems to manage and share the information needed to deliver effective care were co-ordinated across services, supporting integrated care for older patients with complex needs. For example, Patients admitted to hospital were identified and the named GP informed to review them following their discharge. Patients needing end of life care were managed in a coordinated way with the palliative care nurse and community team which meant patient wishes for end of life care could be planned. Feedback from patients whose relatives had received palliative care informed us that the service had been supportive, sensitive and caring

Patients emotional and social needs were seen as important as their physical needs. For example, thee practice had a thorough system in place to support bereavement The practice had a bereavement pack that they supplied with the death certificate. They had produced their own bereavement cards which were sent from the most involved member of the clinical team on behalf of the practice. They had developed a bereavement protocol and were training one of the health care assistants as a bereavement support worker.

To improve patient care the practice has communicated with the Chief Station Officer of the three most local ambulance stations offering a bypass telephone number for immediate access to a clinician if transportation to hospital could be avoided for the patients and an alternative care pathway initiated.

The practice had level access throughout and had undertaken disabled access audits in the past. Actions identified had further improved access for patients in the building. For example an electronic front door, disabled toilet facilities, improved access at reception and changing the flooring. Chairs in the waiting room included those with arm rests to assist patients to stand. Three chairs in the waiting room were higher specifically for those patients

with limited mobility, following feedback from patients. The practice had a bespoke bariatric chair in the waiting room which facilitated not only weight but size a recommendation from a bariatric patient on the in house patient survey.

Every consultation room had an electric couch which could be lowered to allow easier access for elderly patients to be examined. The treatment room had an extra wide couch to accommodate patients who could feel unsafe on a smaller couch.

Stalbridge surgery had provided a paper computer summary for patients to use in emergency situations to provide ambulance and other staff with key information needed. This had the person's essential medical information and was offered to all over 65 year of age and those with chronic disease,. A similar offer was available for patients travelling abroad, so that they had a summary of their medical history to use should they need it if they were taken ill.

The practice had a portable clipboard hearing loop for those patients who were hard of hearing and used it to increase patients involvement in consultations.

In 2012 Stalbridge was offered the opportunity to take part in the national Aortic Aneurysm screening programme. All men over 65 were eligible but had to specifically request this scan themselves. In cooperation with the local screening manager 450 pamphlets explaining this were resourced and sent to all men over 65 years with a covering letter from the practice. A room was made available at the practice for these scans to take place. The response was very good with 253 patients attending between November 2012 and December 2013. Seven patients were found to have aneurysms in the over 65 group that would have gone undetected. Six remained on surveillance and one patient had recently successfully had surgery to improve their health.

The practice held weekly retrospective home visit analysis to ensure we have not overlooked any potential additional follow up arrangements. By the nature of the need for a home visit these are usually amongst the frailest patients.

Following two significant fires in the village, the practice took the opportunity to work with Dorset fire and rescue to actively promote the use of smoke alarms with patients in their own homes at flu clinics.

People with long term conditions

Good

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

Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Long term conditions were managed by the practice nursing team. The nurses had expertise in diabetes management and supported patients with complex needs needing to start using insulin.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice had good relationships with members of the community teams. For example, the GPs liaised well with the long term conditions matron to support those patients with chronic diseases and avoid hospital admissions.
- The practice maintained robust registers and provided appointments for patients with long term conditions. Quality Outcome Framework results indicated an efficient management of chronic disease management with maximum points achieved in the last few years.

Families, children and young people

Good

- 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 patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young patients 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 positive examples of joint working with midwives, health visitors and school nurses. The midwife held a regular clinic at the practice.
- Safeguarding was discussed at significant events meetings within the other professionals form the community. The practice had a protocol that identified all patients who attended under the age of 18 and information was collected

Summary of findings

about who was accompanying the young person and whether they had capacity to consent as outlined in the Gillick competence framework, in addition to details of how to contact and inform the young patient if necessary after any tests.

- Staff were well trained in emergency care. For example, two advanced nurse practitioners were booked on a repeat PILS (Paediatric Immediate Life Support) course for 2016 having successfully completed this in 2014. Also the practice nurse and three health care assistants attended paediatric basic life support in March 2016. All staff received domestic violence training, which had raised their awareness in being able to recognise this and offer support to patients who could be experiencing it.
- The practice website had a dedicated on common aspects of child health.

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. The practice also actively used social media to share health promotion and other practice information.
- The practice were proactive in health promotion and screening. For example, they liaised with the NHS Abdominal Aortic Aneurysm (AAA) screening programme. This was a way of detecting a dangerous swelling (aneurysm) of the aorta (the main artery of the body).
- The practice offered the Fit for Work scheme. This was anew support service, designed to help working people who face long-term sickness absence return to work more quickly

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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless patients, and those with a learning disability. The practice offered longer appointments for patients with a learning disability and double appointments were offered to travellers.
- The GP and nurses undertook annual health reviews for patients with learning disabilities who lived in local care homes. We were told that the practice were responsive to the individual patient, for example one patient had to be visited three times as they became too anxious to complete their health review. We were told that the GP and nurse had been patient and understanding and the patient was never rushed. The practice had completed 86% of annual health checks for patients with a learning disability in 2014/2015.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice held monthly meetings with the manager of the local home for patients with learning disabilities to discuss and update any issues regarding their care.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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).

- 93.33% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the national average of 84.01%. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia. Any relevant information for at risk patients in this group were shared with out of hour's providers to provide continuity of care.
- The practice had informed patients experiencing poor mental health about how to access various support groups and voluntary organisations.

Summary of findings

- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice had good relationships with community teams to support patients at home.

Summary of findings

What people who use the service say

The national GP patient survey results published in January 2016. The results showed the practice was performing in line with local and national averages. 235 survey forms were distributed and 123 were returned. This represented 2.68% of the practice's patient list.

- 90.14 % of patients found it easy to get through to this practice by phone (national average of 73.26%).
- 99.37 % of patients were able to get an appointment to see or speak to someone the last time they tried (national average 76.06%).
- 95.8 % of patients described the overall experience of their GP practice as fairly good or very good (national average 85.05%).
- 89.71% of patients said they would definitely or probably recommend their GP practice to someone who has just moved to the local area (national average 79.28%).

As part of our inspection, we also asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received 103 comment cards which were all positive about the standard of care received. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards also referred to being able to get an appointment when they needed and consistency of care from the same GP. Many referred to being made welcome on arrival at the practice.

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

We spoke with three health care professionals during the inspection all of whom told us that they had very good communication with the practice and that the practice was proactive and responsive in providing good patient care. We also spoke with two care home managers they both were very happy with the service provided by the practice, they said all of the staff were extremely caring and worked hard to give their patients the best care.

The practice sought the views of patients in regard to the service they receive and have conducted many surveys. The practice also encouraged feedback in the friends and family test. The last results (January 2016) found that out of 34 respondents, 31 would be extremely likely or likely to recommend the practice, two were neither likely nor unlikely and one was extremely unlikely.

Outstanding practice

The culture of the practice focused on community engagement and being central to community life. Patients benefited from this emotional and physical well-being support

The practice had a thorough system in place to support bereavement through staff support, bereavement packs and their own bereavement cards.

The practice nurses performed complex leg ulcer dressings in the practice and also worked with the dermatology department at the local acute trust following extended additional training avoiding the need for patients to travel for these services.

Stalbridge Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission Lead Inspector, a GP specialist adviser, a CQC pharmacist and a practice manager specialist adviser.

Background to Stalbridge Surgery

Stalbridge Surgery was inspected on Tuesday 15 March 2016. This was a comprehensive inspection.

The practice is situated in the town of Stalbridge, Dorset. The practice provides a primary medical service to approximately 4500 patients of a diverse age group.

There is one male GP partner, (a locum is used when required for example when the GP is on holiday). The GP holds managerial and financial responsibility for running the business. They are supported by the practice manager, two advanced nurse practitioners, a practice nurse and three health care assistants. The clinical team are supported by additional reception and administration staff and the dispensary team.

The practice has a dispensary attached. A dispensing practice is where GPs are able to prescribe and dispense medicines directly to patients who live in a rural setting. Stalbridge Surgery dispensed to patients who did not have a pharmacy within a mile radius of where they lived.

Patients using the practice also had access to community nurses, midwives, community mental health teams and health visitors who visit the practice.

The practice is open from 8am to 6pm Monday to Friday in line with local contract agreements.. Extended hours are offered on a Saturday morning from 9am until 12.30pm. Outside of these times patients are directed to contact the South West Ambulance Service Trust out of hour's service by using the NHS 111 number.

The practice provided regulated activities from its primary location at Station Road, Sturminster Newton, Dorset

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 15 March 2016. During our visit we:

- Spoke with a range of staff (insert job roles of staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members

Detailed findings

- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.'

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

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

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

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

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

Good

Are services safe?

Our findings

Safe track record and learning

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

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events. For example, where a patient collapsed near to the practice, the practice were alerted andresponded by going to the patient taking with them the defibrillatorand emergency medicines. The patient was resuscitated until the ambulance crew arrived 20 minutes later. Following this incident the event was discussed and all staff were praised and offered training in the use of the defibrillator so that all staff could respond to an emergency if required again.
- We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. All safety alerts were circulated to the relevant member of staff. Any national equipment or medicine safely alerts received that may compromise patient care prompted a search on the computer system for any patients affected, they were then contacted to inform them of any actions needed.

When there were unintended or unexpected safety incidents, patients received support, truthful information, an apology and were told about any actions to improve processes to prevent the same thing happening again.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. The GP was trained to the appropriate levels in children and adult safeguarding..
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service check (DBS check). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken, the last one being undertaken in October 2015. No issues were identified at that time.
- The practice was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. The arrangements for managing medicines, including controlled drugs, emergency medicines and vaccines, kept patients safe (including obtaining, recording, handling, storing and security).Arrangements were in place to ensure that patients were given all the relevant information they required. The practice had written procedures in place for the production of prescriptions, and dispensing of medicines, which accurately reflected current practice. There were systems in place for the management of repeat prescriptions and high risk medicines requiring extra monitoring. Systems were in place to ensure that all prescriptions were checked and signed by the prescriber, before being handed out to patients. Dispensed medicines were checked by a second dispenser, to help reduce the risk of any errors. Some medicines were made up into blister packs to help patients with taking their medicines, and safe systems were in place for dispensing and checking these.
- The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained.

Dispensing staff had all completed appropriate training and had their competency regularly reviewed. Prescription pads and prescription printer paper were securely stored and there were systems in place to audit and monitor their use. Two of the nurses had qualified as Independent Prescribers and could therefore prescribe medicines for specific clinical conditions. Patient Group Directions (PGD) were used by the practice to allow non-prescribing nurses to administer some vaccines in line with legislation. The practice had a system for production of Patient Specific Directions (PSD) to enable Health Care Assistants to administer some other vaccines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Detailed medicine reviews were carried out by dispensary staff, for both dispensing and non-dispensing patients.

- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty.

Arrangements to deal with emergencies and major incidents

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

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patient's needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 96% of the total number of points available, with 2.8% exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed;

- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the previous 12 months was 96.53% which was much higher to than the national average of 88.3%.
- The percentage of patients with schizophrenia, bipolar affective disorder and other psychoses whose alcohol consumption has been recorded in the preceding 12 months was 89.47% which was better than the national average of 89%.
- The percentage of patients with physical or mental health conditions whose notes recorded smoking status in the last 12 months was 91.57% which was similar to the national average of 94.1%.
- The percentage of patients with hypertension in whom the last blood pressure reading measured in the preceding 12 months is 150/90mmHg or less (01/04/2014 to 31/03/2015) was 87.2% which was better than the national average of 83.65%
- The average daily quantity of hypnotic medicine prescribed per specific therapeutic age group was 0.18 which was similar to the national average of 0.26.
- Clinical audits demonstrated quality improvement. There had been seven clinical audits completed in the last two years. All of these were completed audits where the improvements made were implemented and monitored. For example, an audit was performed as a result of a feedback received from the district hospital regarding the combining of two medicines, (one used to treat certain cancers and an antibiotic). The effect of combining the two could have led to potentially life threatening complications. The practice immediately audited all patients, searching for those on the cancer therapy and added information to show the other antibiotic medicine as an allergy. This was a safety net to prevent it being prescribed.

Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those staff reviewing patients with long-term conditions. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support

Good

Are services effective?

(for example, treatment is effective)

during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had had an appraisal within the last 12 months. Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

- The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.
- This included care and risk assessments, care plans, medical records and investigation and test results. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.
- The practice monitored two week suspected cancer care referrals into secondary care to ensure that none were missed.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

Consent to care and treatment

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

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.

The practice's uptake for the cervical screening programme was 82.42%, which was comparable to the national average of 81.83%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. At the introduction of the bowel screening programme to Stalbridge in 2008 those aged 70 and above were allowed to participate in the programme if they opted in. However, they could only opt in if they were aware of the programme so the practice wrote to all patients over 70 explaining how they could participate. One patient who would have been excluded took up this offer and was diagnosed with colorectal cancer and was then able to seek early treatment. This practice is ongoing.

In 2012 Stalbridge was offered the opportunity to take part in the national Aortic Aneurysm screening programme. All men over 65 were eligible but had to specifically request this scan themselves. In cooperation with the local screening manager 450 pamphlets explaining this were resourced and sent to all men over 65 years with a covering letter from the practice. A room was made available at the practice for these scans to take place. The response was very good with 253 patients attending between November 2012 and December 2013. Seven aneurysms were found in the over 65 group that would have gone undetected. Six remain on surveillance and one patient has recently successfully had surgery to improve their health. This practice is ongoing.

Good

Are services effective?

(for example, treatment is effective)

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 47.7%% to 100% and five year olds from 88.1% to 97.6%.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

Improving and/or maintaining quality of life was seen as a key element of a patient's wellbeing and health and patient's emotional and social needs were viewed as being as important as their physical needs. In particular, people with disabilities, the bereaved, those with long-term conditions. We also observed that staff were highly motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. They were fully committed to working in partnership with patients and other agencies to achieve the highest standard of care. We also heard of many acts of kindness by members of staff in their own time, which supported patients to receive the high quality of physical and emotional care and support that the practice continually strove to achieve. For example:

Staff members told us of numerous occasions when they had visited a patient in their home on their own way home and therefore in their own time to deliver medicines or change dressings, when that patient had been unable to attend the practice. Another example given was when a patient became ill whilst in the practice but had their dog with them. Arrangements were made for the patient to go to hospital and arrangements were made for someone else to look after their dog. The practice provided support considered to be above and beyond that which was expected with regards to palliative care patients. Each patient had priority in terms of appointments, telephone contact or visits from their preferred GP. The GP gave out their own mobile telephone numbers to these patients and continued to visit them on days off, weekends and evenings. Each patient was discussed monthly at a dedicated multidisciplinary meeting with representatives from the district nurses and the local hospice.

All of the 103 patient Care Quality Commission comment cards we received were highly positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG). They also told us they

were satisfied with the care provided by the practice and said their dignity and privacy was respected. Care Quality Commission comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey (July 2015) showed patients felt they were treated with compassion, dignity and respect. The practice was similar for its satisfaction scores on consultations with GPs and nurses. For example:

- 87.3% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91.6% and national average of 88.6%
- 90.9% of patients said the GP gave them enough time (CCG average 90%, national average 86.6%).
- 96.4% of patients said they had confidence and trust in the last GP they saw (CCG average 96.4%, national average 95.2%)
- 80.54% of patients said the last GP they spoke to was good at treating them with care and concern (national average 85.34%).
- 95.53 % of patients said the last nurse they spoke to was good at treating them with care and concern (national average 90.58%).
- 90.8% of patients said they found the receptionists at the practice helpful (CCG average 90.4%, national average 86.8%)

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us

they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

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

- 83.4% % of patients said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 89.4% and national average of 86.0%
- 83.35 % of patients said the last GP they saw was good at involving them in decisions about their care (national average 81.61%)
- 94.49 % of patients said the last nurse they saw was good at involving them in decisions about their care (national average 85.09%)

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

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room 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. In February 2016, the practice patient population list was 4458. The practice had identified 136 patients, who were also a carer, this amounts to 3% of the practice list.

The practice was proactive and endeavouring to increase their carers register. Patients who were also carers were encouraged to inform the practice of their caring responsibilities, this was demonstrated through posters throughout the practice, on the website and in the practice newsletter. Written information was available to direct carers to the various avenues of support available to them. The practice had an identifier in all new patient packs asking patients to inform reception if they were carers when they joined the practice. The practice posted out the Dorset Carers in Crisis leaflet to all the identified carers. This leaflet allowed for an alert to be raised if the carer themselves became unwell. Pop up messages were used on the clinical system to alert GPs and reception staff so that they could knowingly assist in their needs, for example when making an appointment. All staff had received carer awareness training.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. The practice had a thorough system in place to support bereavement through staff support, bereavement packs and their own bereavement cards.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

- The practice offered extended hours on a Saturday morning 9am until 1230pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had difficulties attending the practice.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately/were referred to other clinics for vaccinations available privately.
- There were disabled facilities, a hearing loop and translation services available.
- The practice provided enhanced services for near patient testing including in-house International Normalised Ratio monitoring (INR). This reduced the burden on hospital clinic waiting times and provided a more cost-effective and convenient service for patients in their local health communities. This had proved very popular with patients prescribed blood thinning medicines as they could be tested and received their ongoing dose regime at the same appointment.

Access to the service

The practice was open between 8am and 6pm Monday to Friday. Appointments were available from 8.30am every morning. Extended practice hours were offered on Saturday mornings between 9am and 12.30pm. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. We were told that if a patient wanted an appointment on the day then they were guaranteed an appointment. All the patients we spoke with and comment cards we read confirmed this.

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

- 93.19% of patients were satisfied with the practice's opening hours compared to the national average of 78.3%.
- 90.14% of patients said they could get through easily to the practice by phone (national average 73.26%).
- 62.3 % of patients said they always or almost always see or speak to the GP they prefer (national average 36.17%).

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.The complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.There was a designated responsible person who handled all complaints in the practice. We saw that information was available to help patients understand the complaints system this included information on the website and in the patient leaflet.

We looked at three complaints received in the last 12 months and found complaints were satisfactorily handled and dealt with in a timely way, with openness and transparency. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a patient had complained about a change in their medicines meaning they would have to collect the prescription at the practice in person. This was discussed with the GP and the reasoning was that the patient's treatment needed closer monitoring. However this had not been communicated well to the patient.

Are services well-led?

Good

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

Our findings

The practice had a clear vision to deliver high quality care and promote good outcomes for patients.

- The practice had a mission statement which was displayed in the waiting areas and staff knew and understood the values. Staff said there was an ethos of team work with a culture of putting patients first.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

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

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

Leadership and culture

The one GP partner in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritise safe, high quality and compassionate care. The GP was visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents

When there were unexpected or unintended safety incidents:

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

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

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG which met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, an open evening was held at the local library on 'The Health of Stalbridge Surgery' in August 2015. Over 50 patients attended, and a presentation was given by the GP. A medicines amnesty month was launched in October 2015. The practice had a bespoke leaflet printed and also reprinted the antibiotic guardian leaflet for patient information. The aim was for patient's to clear their cupboards of out of date or no longer needed medicines either prescribed or over the counter and also to avoid over ordering and stockpiling and think carefully about antibiotic usage.

Are services well-led?

Good

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

- The practice had gathered feedback from staff through daily informal discussion and through more formal structured meetings and appraisals. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice had also gathered feedback from medical students and GP trainees. The last feedback was consistently positive.

Continuous improvement

Staff explained that there was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and had developed innovative ways at collecting data at the same time as improving patient care. Systems were continually being looked at to improve care for the patients, for example the weekly analysis of home visits to try and establish any patterns or improve outcomes for patients to help them avoid unnecessary unplanned admissions to hospital.

The practice had completed reviews of significant events and other incidents and shared findings with staff both informally and formally at meetings to ensure the practice improved outcomes for patients. Records showed that regular clinical audits were carried out as part of their quality improvement process to improve the service and patient care. The results of feedback from patients, through the patient participation group, patient feedback board, family and friends test, were also used to improve the quality of services.