Barton House Medical Practice

Quality Report

Barton House
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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.

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Overall summary

Barton House is a purpose built practice located at Beaminster, Dorset DT8 3EQ. The building was designed to meet the needs of disabled people and had full wheelchair access. Services were provided by three GPs, a registrar GP and a small team of practice nurses. A dispensing service was available within the practice. A practice manager had responsibility for the oversight of day to day practice activities. The service was supported by an active patient participation group.

The practice comprised of one location in the centre of Beaminster, Dorset. The regulated activities we inspected were Diagnostic and screening procedures; Maternity and midwifery services; Surgical procedures and Treatment of disease, disorder or injury.

Our inspection took place on Tuesday 3 June 2014 and involved four inspectors over a nine hour period. We found the provider had taken steps to ensure their service was safe for the patients it provided services to as well as to the staff employed there. There were systems in place to ensure effective patient care and we heard about a high level of patient satisfaction with the services provided. Patients were treated with dignity and respect in a purpose built environment which was accessible and ensured their privacy. Appointments were available at times which suited the majority of patients. In the event of patients requiring to be seen urgently there was provision to accommodate their needs. Information was available for patients who required out of hour's care on the provider's website, in the practice and on their telephone system. The practice was well led by the registered manager and their partner GPs and nursing team. They were supported by an engaged practice manager and staff team.

We spoke with 18 patients and received comment cards from a further 22 patients. We also spoke with three representatives of the patient reference group. All the views expressed by these people about the practice were very positive with a collective view that patients were at the centre of the practices service delivery.

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. The patient groups were;

- Older People
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing a mental health problems

They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. However, they told us they found it difficult to identify specific services which could be applied to these groups as many patients fell into multiple groups at the same time.

The provider cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

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The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall the practice was safe. The provider had a range of safe systems in place to ensure the safety of patients who used their practice. These systems included safe patient care and appropriate use of equipment to support the patient when in the practice or when they required support at home. The environment was purpose built; effectively maintained and was kept clean and tidy through effectively maintained hygiene and infection control measures. All staff in the practice ensured vulnerable patients were cared for appropriately and where there were concerns about a patients vulnerability, the relevant authorities were alerted. Medicines management was effective within the small dispensing service; medicines were dispensed by appropriately trained and qualified staff. There were sufficient emergency medicines and equipment in place to ensure non planned medical emergencies could be managed effectively.

Are services effective?

Overall the practice was effective. Care, treatment and support provided by the practice was effective with all patients stating strong satisfaction about the treatment they received. The provider took account of best practice guidance and ensured all staff in the practice had access to information about improving outcomes for patients. Outcomes for patients were routinely monitored and reviewed, and appropriate health care management plans were put in place to support patients. Staff were supported well by the provider and had access to information and training which helped them develop as individuals and as part of the practice team. Health promotion and prevention was provided as a matter of course by clinicians who engaged effectively with patients.

Are services caring?

Overall the practice was caring. Patients told us about the excellent levels of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We heard detailed stories about how clinical staff supported them when their partners were dying, about effective pain management for the person dying and the high degree of emotional support they received. Patients told us their privacy was respected during treatment and when waiting for appointments. All clinical staff were aware of the 'Gillick competency' and 'Fraser guidelines' (These are tools used to decide whether a child (16 years

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or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge) when deciding whether a child was mature enough to make decisions for themselves. Services were provided by caring and involved staff.

Are services responsive to people's needs?

Overall the practice was responsive to patients needs. The practice understood the different needs of the population it served and acted on these to design services. The practice had established a patient reference group (PRG) to help understand patient needs. The practice had worked with the group when carrying out patient surveys and had jointly identified areas of practice improvement. Information available in the practice promoted good health and wellbeing. The clinical teams worked with patients to promote self-care and patients independence in a responsive way. Patients spoke positively about how continuity of care by doctors and other team members was provided; for example, appointments with a named doctor where possible. This was maintained as each GP had their own specific patient list and reception staff routinely offered available appointments to the patients preferred clinician. Patients told us the appointments system was easy to use and provided choice for patients to access the right care at the right time. The practice had a clear complaints procedure which provided clear statements of how a response would be handled, who was responsible for managing the complaint and the time frame they could expect a response within. There had been very few complaints to or about the practice.

Are services well-led?

Overall the practice was well-led. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other. This view was corroborated by patients who told us they felt the practice was well led and there was a positive culture of patient care. Governance arrangements were effective and supported transparency and openness. We saw the provider had a range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance. The practice was proactive in gaining patient feedback. A patient survey was carried out in February 2014 by the practice in conjunction with the patient reference group. The survey showed high levels of patient satisfaction with the services provided. Risks were managed and monitored effectively and learning was taken from day to day occurrences and incident or complaints to improve the practice.

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

Our accompanying GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We saw the practice supported residential care homes and nursing homes by making visits to patients living in these types of homes as well as visiting elderly patients in their own home. We saw how one GP had a responsible role for palliative care and how they supported elderly patients nearing the end of their life.

People with long-term conditions

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We saw how one GP had a responsible role for palliative care and how they supported patients with long term conditions nearing the end of their life. We heard about effective partnership working with other professionals as well as prompt referrals for patients with long term conditions.

Mothers, babies, children and young people

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care

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We heard about effective partnership working with community based nurses and midwifery services who supported mothers with babies and young children. We heard how the practice referred concerns about children in need to the local authority and how GPs worked with them to support children's wellbeing. We heard how a carers group was available to patients with a caring role.

The working-age population and those recently retired

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We saw the practice had listened to feedback from patients and how they increased the times the practice remained open to support the working age population and those recently retired. We heard how a carers group was available to patients with a caring role as well as lifestyle advice and information available to patients in this group.

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

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as

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being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We heard about effective partnership working with other professionals as well as prompt referrals for patients in vulnerable circumstances.

People experiencing poor mental health

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We heard about effective partnership working with other professionals as well as prompt referrals for patients experiencing a mental health problem.

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What people who use the service say

A patient survey was carried out in February 2014 by the practice in conjunction with the patient reference group. The survey showed high levels of patient satisfaction with the services provided. For example 97% of the 96 patients who responded were satisfied they could see the GP or nurse of their choice; a similar percentage of patients were satisfied that waiting times were reasonable. Where less favourable comments were made, for example about the use of a 0844 number to contact the practice, we saw the practice had reverted to a 01308 number. We saw the results of the survey had been made available to all patients on the provider's website alongside the actions agreed as a consequence of the patient feedback.

During our inspection all of the 18 patients we spoke with told us the practice was excellent and they had a high level of satisfaction with all services, whether provided by the GPs, the nursing team or from the reception and administrative staff. Patients commented they were able to see the GP of their choice at a time which suited them and that they received treatment in a safe and effective way. They also commented that the environment was always clean and tidy and where they had suggestions for practice improvement that these suggestions were listened to.

Three of the patients we spoke with were representatives from the practices patient participation group. This was a virtual group which communicated via email and helped provide feedback to the practice; there were plans for the group to meet directly with the practice once or twice each year. The group members were complimentary about the practice and about how the practice listened and responded to suggestions for practice improvement. They all told us they felt the practice provided safe and effective care and treatment in a clean and well managed environment.

We received comment cards from twenty two patients. All the cards we received provided positive comments about the practice. Where comments also made suggestions about less satisfactory aspects of the practice, we heard how these had also been discussed with the practice manager or GP. We spoke with the patients who raised these comments. They told us they had been provided with more information by the practice and they were better informed in how to avoid a repeat of the events which concerned them. Patients who made positive comments about the practice talked about exceptional doctors who listened and put patients first. They also highlighted how access to consultants and specialists was done promptly and how staff worked hard to keep patients informed.

Areas for improvement

Action the service COULD take to improve

Two separate staff members told us about routine monthly audits of expiry dates for emergency medicines. All the medicines seen were in date and fit for use however an audit trail showing when the checks took place was not routinely available.

Temperature monitoring in the dispensary was not routinely undertaken.

In the staff records we looked at, not all staff with an existing disclosure and barring service certificate had had their certificates checked to see if amendments had been applied.

All surgeries were separated from the waiting area however they did not benefit from locks to the doors this might result in other practice staff inadvertently entering the room during an examination.

We were told about an oversight of audits which routinely took place within the practice; however there were few records of these checks made to enable us to substantiate these statements.

Summary of findings

Good practice

Our inspection team highlighted the following areas of good practice:

We heard about a carers support group which one of the practices administration team set up and managed. The carers group won an award from the Wessex Royal College of General Practitioners for innovative services for carers and a similar Dorset Surgeries award for support offered to carers. The service is triggered when anyone in the practice identified a patient who had a caring role. The person's details were passed to the carer group co-ordinator; they then contacted the person to find out if they had any support or information needs. On-going support ranged from simple telephone conversations to referrals to support groups or services as well as group meetings. Carers who had been contacted by this group stated they had found it invaluable and supportive in managing their particular circumstances.

A library of information for staff had been set up on the providers computer system by one of the GPs that enabled swift access to health related conditions and best practice.

The practice was a GP Training Practice, and as such normally had a GP Registrar attached. A GP Registrar is a trainee GP in their final years of training, gaining GP experience before entering General Practice as a fully qualified GP. The current Registrar GP was near the end of their training period and had completed all their examinations.

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Detailed findings

Our inspection team

Our inspection team was led by:

A Care Quality Commission Lead Inspector. In addition, the team included a GP with thirteen years clinical experience, a judicial role as part of HM Courts and Tribunal Service and as a Medical Education practitioner. A pharmacist with 14 years' experience inspecting for the Care Quality Commission across health and social care service types and a background which involved hospital and community pharmacy and as a prescribing advisor. A practice manager with nine years' experience in their current role and significant operational manager experience supporting GP practices.

Background to Barton House Medical Practice

The practice was located at Barton House, Beaminster, Dorset. DT8 3EQ. The practice is located in the centre of a medium size market town in West Dorset and supports around 5,700 patients in an approximate 5 mile radius of the town. The population is predominantly White British or white other with 0.2% of patients from minority ethnic groups. The majority of patients are aged between 45 and 85 years with the practice supporting one residential care home and three services for people with learning disabilities on the autism spectrum. There were slightly more females than males registered with the practice. The patient reference group is made up of a representative mix from the patient group.

The practice is open 5 days a week and provided patient appointments between 9:00am and 18:00pm with three GPs providing appointments on Monday and Friday and two GPs covering Tuesday to Thursday. Additional appointments were available to patients unable to attend the practice during normal opening hours; these were available by prior arrangement 4 days a week. GPs also offered telephone advice to patients once their normal practice hours were over. The practice provided telephone information about out of hours and emergency appointments. This information was also available in the practice brochure and on their website.

Why we carried out this inspection

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

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How we carried out this inspection

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

- Is it safe?

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

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

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

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 3 June 2014 between 8am and 6pm.

During our visit we spoke with a range of staff, including the registered manager and other GPs, the practice manager, practice nurses, pharmacy and reception staff and administrative staff.

We also spoke with patients who used the service. We observed how people were being cared for and reviewed personal care or treatment records of patients.

Are services safe?

Summary of findings

Overall the practice was safe. The provider had a range of safe systems in place to ensure the safety of patients who used their practice. These systems included safe patient care and appropriate use of equipment to support the patient when in the practice or when they required support at home. The environment was purpose built; effectively maintained and was kept clean and tidy through effectively maintained hygiene and infection control measures. All staff in the practice ensured vulnerable patients were cared for appropriately and where there were concerns about a patients vulnerability, the relevant authorities were alerted. Medicine management was effective within the small dispensing service; medicines were dispensed by appropriately trained and qualified staff. There were sufficient emergency medicines and equipment in place to ensure non planned medical emergencies could be managed effectively.

Our findings

Safe Patient Care

Patients were able to access the GP of their choice during the opening hours of the practice. The GPs held their own patient lists which enabled continuity of patient care and respected the choices made by patients in regard of their GP choice. Appointment times varied based on patient needs; appointments varied from a 5 minute telephone discussion appointment to twenty minute consultation appointments. Longer appointments were available if required, for example if a patient needed to have an examination with the practice nurse. Emergency appointments were available each working day and the practice had extended working hours up to 7:00pm four days each week.

The GPs and nurses we spoke with told us about routine condition and medicines reviews. The patients we spoke with confirmed these reviews. Patient care was provided by clinicians who routinely updated their knowledge and skills from a variety of sources. For example, attending learning events provided by the clinical commissioning group, completing online learning courses and reading journal articles. Learning also came from clinical audits. For example, audits of patient records by a designated nurse identified higher than average referral rates to dermatology specialists. The GP attended a course to update and improve their knowledge and skills of this area. This meant some treatments could be provided within the practice resulting in better outcomes for patients. Subsequent audits showed there has been a slight reduction in referral rates following this skills update.

The practice has an electronic patient record system as well as an older paper based system. Alerts were placed on the electronic patient record to indicate significant medical concerns about patients as well as allergies or the need for additional support. These alerts appeared immediately when the patient record was opened and alert the clinician to anything significant relating to the patient and the patients care. Routine recall appointment alerts were entered onto the system to ensure patients were reminded to have their medical conditions reviewed. This prevented patients from missing important medical reviews and ensured their care and treatment was effectively met.

Are services safe?

Learning from Incidents

There had been very few incidents relating to the practice. Where an incident had occurred, we saw there were effective measures in place to learn from the incident and avoid repeated problems. For example, where there had been a dispensing error with a medicine we saw the incident had been investigated to find out how the problem occurred. We heard from the practice manager how they and the dispensary manager reviewed the incident and amended the dispensary procedures to reduce the risk of the incident recurring. We saw that this information was passed on to staff at a subsequent staff meeting. There had been no further incidents relating to this type of error.

The GP we spoke with told us about learning from every day occurrences as well as complaints. They told our accompanying GP that complaints also provided learning. These were managed by the practice manager and learning was then shared with staff once the complaint was resolved to the patients satisfaction. This was confirmed in the staff meeting minutes we saw.

Safeguarding

One of the GP partners had a practice lead responsibility for ensuring safeguarding of vulnerable adults and children and there was a practice expectation that all GPs were level 2 trained and aware. We were told that all three GPs completed annual safeguarding training. There were appropriate policies evident and seen in the practice as well as Department of Health and Local Authority guidance regarding supporting all vulnerable patient groups. We were told by the registered manager there had been no major issues over the last year. There were a number of children known to the practice on the child protection register but no specific incidents had been reported. The practice held a vulnerable family register. This included families where an individual may have a social, drug, alcohol or learning problem as well as children at risk. The register gave clinicians an awareness of the family as a whole and was revised every two months. GPs and the practice manager were the only staff with access to the register and this was password protected.

All the staff we spoke with demonstrated a good understanding of the types of abuse which might occur as well as the signs and symptoms of abuse. We saw telephone numbers of relevant agencies relating to safeguarding concerns were available in the practice. The staff we spoke with told us they had completed safeguarding training and this was confirmed when we looked at the training records for those staff. Clinical staff were aware of the Gillick competence requirements and ensured children were accompanied by an adult if they needed to see a GP until such a time as they could demonstrate consent to their own treatment.

The patients we spoke with told us they felt safe in the practice and that their care and support was delivered by competent and professional staff. The practice had a chaperoning policy available to all patients which ensured all vulnerable patients had the opportunity to see a GP or nurse accompanied by a skilled and knowledgeable chaperone. This policy also supported the safety of staff.

Monitoring Safety & Responding to Risk

We saw that staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. For example, three GPs were available on Monday and Friday whilst there were two GPs available on the other weekdays; a registrar GP was also available. Practice nurses were similarly flexibly available as was the phlebotomist (a person trained to take blood samples). These levels of staff were seen during our inspection. This showed the right staffing levels and skill-mix was sustained at all hours the practice was available to help ensure safe, effective and compassionate care and levels of staff well-being.

We saw a range of information was available within the practice which provided details of organisations patients or staff could contact if physical health emergencies or mental health crises occurred either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available in the practice. Staff told us how they recognised and responded to changing risks within the practice, for people using the service and for staff. Staff told us about recent training they had received in what to do in an urgent or emergency situation and about the practices procedure in such circumstances.

We saw there was sufficient and up-to-date emergency equipment available for use by all trained and competent staff working in the practice. Routine checks of this

equipment were undertaken by designated staff members. Emergency medicines were also available in a central area of the practice and were routinely audited to ensure all items were in date and fit for use.

Medicines Management

We took a pharmacist with us during our inspection to help provide specialist knowledge of dispensary services within a GP practice. They found the dispensing service was overseen by a dispensary manager with support from qualified and trained reception staff. The dispensing area was adjacent to the reception area and was not accessible to patients other than via the small counter area where prescriptions were collected. A clear dispensary procedure was available within the practice. All staff had signed a document which indicated they had read and understood the procedure. The procedure covered ordering, checking and dispensing of medicines and controlled drugs. It also covered the receipt of returned medicines, repeat prescriptions and prescription authorisation processes. These helped ensure the safe dispensing of medicines to patients.

The dispensary was clean and tidy with well organised medicines storage. Medicines which required storage in a refrigerator were stored appropriately and within the safe temperature ranges described in the medicines packaging. Fridge temperatures were monitored and recorded daily. Vaccines were similarly safely stored. Controlled drugs were held securely in a specifically designed cabinet with keys accessible to a limited number of the practice staff.

Two separate staff members told us about routine monthly audits of expiry dates for emergency medicines. All the medicines seen were in date and fit for use, however an audit trail showing when the checks took place was not routinely available. Temperature monitoring in the dispensary was not routinely undertaken.

Where medicines were reaching their expiry dates there was a sticker system in place to ensure these were prioritised for use. Prior to dispensing, these were checked again to ensure they were safe to use for the entire period of the medication course. This ensured patient safety and the effectiveness of their treatment.

Prescription pads were held securely in the dispensary. Serial numbers of the pads were recorded on receipt to ensure accountability and to aid auditing. When given to GPs, the serial number of the pad was recorded and the pad became the responsibility of the GP. Controlled medicines prescriptions were kept in the locked controlled medicines cabinet until they were required. Keys for the cabinet were held in the practice safe and were only accessible in the presence of a GP.

Cleanliness & Infection Control

Patients were cared for in a clean, hygienic environment. We carried out a visual check of all areas of the practice and observed that all areas appeared clean, tidy and free of items which may cause infection control risks. Clinical areas of the surgeries had designated clinical spaces with surfaces which could be wiped clean. Appropriate personal protective equipment such as examination gloves and plastic protective aprons were available in these areas and were stored appropriately. There were separate hand and instrument washing facilities with alcohol gels were also available throughout the practice.

One of the practice nurses had a lead responsibility for ensuring effective infection control. Staff had received training to ensure effective hygiene practices were maintained. Appropriate signage was available throughout the practice that reminded staff and patients about good hygiene practices. Annual hygiene audits were undertaken in conjunction with the provider's infection control service. A daily record of all areas cleaned was maintained and routinely checked by the cleaning contractor.

Medical equipment used in patient examinations was mainly single use items which were then disposed of appropriately. Waste bins were foot operated and lined with the correct colour coded bin liners. We saw waste was stored in locked bins until it was regularly collected by a recognised waste disposal contractor. Clinical sharp objects such as needles were disposed of in recognised sealed containers and disposed of in line with current guidance.

Patients were protected from the risk of infection because appropriate guidance had been followed. The practice employed an accredited infection control service to provide cleaning services for the five days of the week the practice was open. We saw the practice used a recognised colour coded cleaning system for mops and cloths as stated in current hygiene guidance. All cleaning materials and chemicals were securely stored and Control of Substances Hazardous to Health (CoSHH) information was available to ensure their safe use. Surgeries were deep cleaned as required and at least annually. The cleaning

contractor we spoke with told us about spot checks which they undertook to ensure appropriate cleaning took place. This was confirmed by the staff we spoke with. This ensured a safe and hygienic environment.

Staffing & Recruitment

The provider had relevant staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. Most staff had been employed by the practice for many years with only two staff having been employed recently. We saw from the paper and computer staff records we looked at that staff had been recruited and employed in line with the provider's policy. For example, following the advertising of a post the application forms had been checked and a short list for interviews had been made. We saw evidence that interview performance had been measured and a decision to appoint had been reached. Verbal and written job offers had been made.

Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development. Disclosure and Barring Service (DBS) checks had also been made. However, not all staff with an existing DBS certificate from another practice had had their certificates checked to see if amendments had been applied.

We saw the current induction plan for a newly appointed member of the receptionist team. The plan showed they had completed many areas based on their role such as telephone answering, patient care and safety, health and safety and fire procedure familiarisation. We saw they were still receiving some training and support around the use of the patient records system and were being closely trained and supervised in the dispensary area ahead of taking on that role. All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Dealing with Emergencies

The provider had arrangements in place to manage emergencies. All staff recently had completed basic emergency first aid training and were able to tell us the locations of all emergency medical equipment and how it should be used. We checked the medical equipment and found it appeared to be in good working order, had recently been checked and was appropriately accessible. Equipment was available in a range of sizes for adult and children.

Emergency medicines were available in a secure area of the practice. All medicines were in date and fit for use and were checked by the practice nurse monthly. They held a list of the medicines expiry dates and had a procedure for replacing medicines at that time.

The providers computer based records system had an alerting system in place which indicated which patients might be at risk of medical emergencies. This enabled practitioners to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable, for example through poor mobility or where epilepsy was diagnosed. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

Emergency appointments were available each day both within the practice and for home visits. Out of hours emergency information was provided in the practice, on the provider's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required. This showed the provider had arrangements in place for dealing with emergencies.

Equipment

We looked at the equipment available within the practice, together with the arrangements in place that ensured the equipment was serviced and safe to use. We saw that equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED) centrally located, all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed current stickers indicating testing. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down, cleaned or sterilised after use. If equipment became faulty or required replacement, these were referred to the practice manager who arranged for its replacement.

Are services safe?

Equipment such as the computer based record system were password protected and backed up to prevent data loss. An online 'Cloud' based system was being developed to provide access to data from other locations to ensure patient records could be accessed externally if access could not be available to the surgery in emergency situations.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall the practice was effective. Care, treatment and support provided by the practice was effective with all patients stating strong satisfaction about the treatment they received. The provider took account of best practice guidance and ensured all staff in the practice had access to information about improving outcomes for patients. Outcomes for patients were routinely monitored and reviewed, and appropriate health care management plans were put in place to support patients. Staff were supported well by the provider and had access to information and training which helped them develop as individuals and as part of the practice team. Health promotion and prevention was provided as a matter of course by clinicians who engaged effectively with patients.

Our findings

Promoting Best Practice

Patients care and treatment needs were assessed and care and treatment are delivered in line with current legislation, standards and guidance. The practice subscribed to a range of medical journals, publications and on line resources which provided and indicated recognised evidence-based practice. Each GP ensured they developed their knowledge and skills through a continuous professional development pathway. The GPs had their professional development checked during appraisal and revalidation; this took place every five years. The practice nurses completed a similar pathway and were supervised by the GPs, the nurses told us they used these opportunities as well as daily GP contact to hear more about best practice guidance.

The provider told our accompanying GP about how they also attended regular meetings in Bridport Medical Centre in relation to clinical guidance. The practice engaged with visiting consultants to help broaden their knowledge base as well as to inform their registrar GP programme. The provider also attended post graduate meetings at Dorchester hospital. An example of where the practice had used best practice guidance followed updated research guidance on atrial fibrillation treatment (irregular heartbeat); this resulted in reviewed use of medication for patients with this condition.

We saw the provider was in routine receipt of the latest Medicines and Healthcare Products Regulatory Agency (MHRA) alerts which enabled the practice to ensure effective treatment of patients. The practice also subscribed to the British National Formulary (BNF) which provided guidance and best practice about the safe use of medicines. This supported the effective treatment of patients.

Management, monitoring and improving outcomes for people

The patients we spoke with who had long term conditions told us their conditions were well managed, routinely monitored and had found their health conditions had stabilised leading to improved heath. For example, where patients required treatment to prevent the formation of blood clots in their blood vessels, an effective management programme was in place. Routine repeat blood test appointments were arranged with the practice nurse. The

Are services effective?

(for example, treatment is effective)

results of the blood tests were evaluated by the clinicians and the appropriate adjustment was communicated to the patient the same day. The practice nurse kept a record of the test results in the patients record book to monitor progress and to identify variations in the patients condition. These routine tests enabled patients to maintain positive health outcomes.

We saw similar monitoring and management programmes for people with diabetes, iron deficiency, heart conditions, prostate cancer, arthritis and near-patient testing for patients on certain drug types. A further example would be where Lithium levels in patients with mental health problems were monitored alongside other tests to ensure the patients mental health remained stable. This type of monitoring supported effective outcomes for patients using the practice.

Staffing

The provider had effective staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. Most staff had been employed by the practice for many years with only two staff having been employed recently. We saw from the paper and computer staff records we looked at that staff had been recruited and employed in line with the provider's policy. Before staff were appointed there was evidence that relevant checks had been made in relation to identity, registration and continuous professional development.

The staff we spoke with told us they all received an annual appraisal and attended regular staff meetings to enable information sharing. The minutes of staff meetings we asked for confirmed this. Nursing staff received clinical supervision from the GP partners with the GPs meeting informally to discuss clinical issues and diagnosis. All staff told us they had access to training related to their roles; all had recently completed basic emergency first aid training. Staff told us they were alerted to concerns about faulty equipment from MHRA alerts by the practice manager. These meant patients were treated effectively by informed staff.

All the staff we spoke with told us they felt well supported by the GPs and nursing team as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role through a range of learning programmes such as on-line learning and in-house training. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with other services

We saw and heard how the provider had effective working arrangements with a range of other services such as the community nursing team; the local authority, local nursing and residential services, the hospital consultants and a range of local and voluntary groups.

The patients we spoke with told us about quick referrals to specialists and consultants for further tests or treatment. The also told us how they were referred to the Carers group for support at times in need as well as community nursing provided services. The patients told us how once they had received test results or treatment their GP received a letter promptly with test results and suggestions for on going treatment and support.

We spoke with the community nurses and they confirmed to us that there were effective working relationships with the practice. They told us referrals were provided in a prompt manner and that when they contacted the GPs for further treatment which was responded to positively and promptly.

Health Promotion & Prevention

The practice offered a range of health promotion and prevention to all patients using the practice. The promotion and prevention was provided as part of normal GP and nursing appointments and was supported by a range of information available within the practice and on the provider's website. Information was available about; health and lifestyle issues such as keeping healthy, living a healthy lifestyle, preventing illness, and preventing any existing illness from becoming worse. Leaflets included information on diet, obesity, smoking, exercise, alcohol, preventing heart disease, cervical screening, breast screening, sun and health.

Information and treatment was also available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support. The practice was also funded to provide complementary support to patients where other treatments had not provided the outcomes expected. Treatments included homeopathy and acupuncture. The patients we spoke with told us that where they received complementary interventions it was

Are services effective?

(for example, treatment is effective)

offered as a result of other treatments not having worked. Half of the patients told us they felt they benefited from the complementary medicines and particularly by the involvement of the GP who provided the practice.

Are services caring?

Summary of findings

Overall the practice was caring. Patients told us about the excellent levels of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We heard detailed stories about how clinical staff supported them when their partners were dying, about effective pain management for the person dying and the high degree of emotional support they received. Patients told us their privacy was respected during treatment and when waiting for appointments. All clinical staff were aware of the 'Gillick competency' and 'Fraser guidelines' when deciding whether a child was mature enough to make decisions for themselves. Services were provided by caring and involved staff.

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with about the practice told us about the excellent levels of treatment they received and the respect, dignity, compassion and empathy they were shown by all members of the practice team. We heard detailedstories about how clinical staff supported them when their partners were dying, about effective pain management for the person dying and the high degree of emotional support they received. Patients told us how they were referred to the Carers group provided by the practice and how this additional support helped them come to term with the loss they experienced.

We saw how the reception staff treated all patients with dignity and respect when they arrived for appointments. Patients were greeted in their preferred manner and conditions were not discussed in a way which could undermine their privacy. The reception area was separate from the waiting area which further aided patient privacy.

When patients were called for appointments, the GP or nurse came out to collect the patient and welcomed them by name. Where patients had poor mobility they supported the patient in getting into the treatment room. All patients were seen in private unless they chose to be accompanied by a partner, parent or chaperone. Surgery doors were closed and clinical examination areas were screened to ensure patient privacy and dignity. All surgeries were separated from the waiting area however they did not benefit from locks to the doors this might result in other practice staff inadvertently entering the room during an examination. We saw no evidence that staff entered the surgeries unannounced during our inspection.

All clinical staff were aware of the 'Gillick competency' and 'Fraser guidelines'. These refer to decisions about whether a child was mature enough to make decisions for themselves and had the ability to be seen alone or with a chaperone rather than with their parents. Where this was the case, we were told patient records would be updated to reflect the current arrangements.

Where patients were losing the capacity to make decisions about their health, we heard how the clinician would liaise with the patients partners or carers and undertake Best Interest decisions to ensure the patient received

Are services caring?

appropriate treatment. Where patients were 'forgetful', we heard and saw how clinical staff spent time with them, explained what was happening and reassured them in a compassionate and dignified way.

Without exception, all patients told us they were made to feel important, involved and at the centre of decision making about their health care.

Involvement in decisions and consent

We saw how patients were involved in their care and treatment throughout their visit to the practice. We saw how new patients were asked to complete new patient information forms which included details of their previous health conditions and current medicines they took. We heard from staff and patients how a first appointment was usually a health assessment consultation and how they signed forms agreeing to their care and treatment.

Patients told us how their GP consulted with them about the choices of treatment available to them and in how that treatment could be provided. For example, the patient could have a treatment carried out in the practice by one of the GPs or if they preferred they could be referred to one of the local hospitals. One of the patients we spoke with told us how they were offered the choice of consultant at one of two regional hospitals and how they were given information about the consultants involved.

Other patients told us about consent forms they signed to agree to the treatment they required. The forms included the risks of the treatment, as well as having the treatment and the alternatives explained. These signed forms were kept on the patient records. This showed patients were consulted with and their choices taken into account.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall the practice was responsive. The practice understood the different needs of the population it served and acted on these to design services. The practice had established a patient reference group (PRG) to help understand patient needs. The practice had worked with the group when carrying out patient surveys and had jointly identified areas of practice improvement. Information available in the practice promoted good health and wellbeing. The clinical teams worked with patients to promote self-care and patients independence in a responsive way. Patients spoke positively about how continuity of care by doctors and other team members was provided; for example, appointments with a named doctor where possible. This was maintained as each GP had their own specific patient list and reception staff routinely offered available appointments to the patients preferred clinician. Patients told us the appointments system was easy to use and provided choice for patients to access the right care at the right time. The practice had a clear complaints procedure which provided clear statements of how a response would be handled, who was responsible for managing the complaint and the time frame they could expect a response within. There had been very few complaints to or about the practice.

Our findings

Responding to and meeting people's needs

The practice understood the different needs of the population it serves and acted on these to design services. The practice had established a patient reference group (PRG) to help understand patient needs. The group was made up of a representative sample of the patient receiving services but with a slight bias towards patients over retirement age. The practice had worked with the group when carrying out patient surveys and had jointly identified areas of practice improvement. The practice had recently added the facility of a suggestion box and suggestion cards to gain patient feedback and had also used information from complaints to improve the practice.

We saw how appointment times had been provided into the early evening on four days each week to help working families. Contacting the practice by phone had been changed to a local telephone number rather than a 0844 number following patient feedback; and a parking refund was available if GP appointments ran beyond thirty minutes. Further surveys were planned to help improve the practice.

The patients we spoke with told us services were planned in a way that promoted person-centred and coordinated care, including for people with complex or multiple needs. Patients and GPs told us about referrals to consultants, treatments provided in hospitals and how their own GP followed these appointments with additional care and support.

Information available in the practice promoted good health and wellbeing and the clinical teams worked with patients to promote self-care and patients independence. Follow up appointments of telephone calls were made to patients with long term conditions to ensure they were following clinical guidance and to remind them to attend their appointments.

Patients spoke positively about how continuity of care was provided by doctors and other team members; for example, appointments with a named doctor where possible. This was maintained as each GP had their own specific patient list and reception staff routinely offered available appointments to the patients preferred GP.

Since building the purpose built practice, the provider had been proactive in making reasonable adjustments to the

Are services responsive to people's needs?

(for example, to feedback?)

practice. They had recognised the problems an upstairs surgery might cause and had built an extension to ensure all surgeries were on the ground floor and the dispensary area was better ventilated. The provider ensured the environment and facilities were appropriate and required levels of equipment were available in all surgeries. An on-going maintenance programme was in place.

Access to the practice

The patients we spoke with told us the appointments system was easy to use and provided choice for patients to access the right care at the right time. People who used the practice were easily able to contact the practice to make an appointment. Appointments could be made by telephone or by using the provider's online appointment booking system.

Opening hours had been amended and now met the needs of the majority of the practices population. Opening hours were clearly stated on the entrance to the practice, in the practices brochure and their personal and NHS Choice website. The appointments system was monitored to check how the appointments system worked and to highlight where non-attendance occurred.

There was a system in place to enable requests for same-day appointments to be met. We spoke with three patients who had phoned up that morning and were offered appointments to see a GP; they expressed satisfaction with this response. The practice monitored its systems for appointments and waiting times and informed patients when delays had occurred.

Patients were able to be assessed by a GP in a timely way which meets their needs. This included, for example, urgent appointments if needed or telephone consultations and home visits for patients that would benefit from them. We saw there were a range of appointment slots available from short telephone conversation consultations to ten minute single and twenty minute double appointments. Longer appointments were also available where minor surgery was being provided.

Concerns & Complaints

The majority of patients told us they knew how to raise concerns or make a complaint about the practice. The provider's complaints procedure was promoted on the patient notice board, in the practice's brochure and on their website. Where patients were unsure of the policy, they told us they felt that if they complained to the doctor or receptionist their complaint would be listened to and acted on.

The practice had a clear complaints procedure which provided clear statements of how a response would be handled, who was responsible for managing the complaint and the time frame they could expect a response. There had been very few complaints to or about the practice. Where complaints had been made we saw they were responded to as described in the provider's policy and in writing to the patient. Where complaints were about staff, we saw the practice manager spoke with those involved and offered them support to improve their performance. This ensured that performance was reviewed and services were improved for patients.

Patients who made informal complaints or comments about the practice told us the provider had handled their complaint effectively, and treated them with respect throughout the process. The provider explained in writing in an open and honest way what had happened as a result of the issues being raised. All the patients we spoke with told us they had no current concerns about the practice which indicated a high level of patient satisfaction with the practice.

Are services well-led?

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

Summary of findings

Overall the practice was well-led. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other. This view was corroborated by patients who told us they felt the practice was well led and there was a positive culture of patient care. Governance arrangements were effective and supported transparency and openness. We saw the provider had a range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance. The practice was proactive in gaining patient feedback. A patient survey was carried out in February 2014 by the practice in conjunction with the patient reference group. The survey showed high levels of patient satisfaction with the services provided. Risks were managed and monitored effectively and learning was taken from day to day occurrences and incident or complaints to improve the practice.

Our findings

Leadership & Culture

The practice had three partners each of who had lead roles in areas such as Palliative Care, Complementary Medicine Nutrition and Dermatology and Safeguarding. One of the partners also had a lead responsibility for GP Training and the supervision of the current registrar GP. The practice manager took lead responsibility for the day to day management of the practice and acted as a link between the GPs, staff and patients. The Practice Nurse had responsibility for infection control and ensured adherence to practice policy across the staff team. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other.

Staff were able to tell us about the values and philosophy of the practice and this encompassed key concepts such as compassion, dignity and respect, equality, quality and which placed the patient at the centre of their decision making. This had been developed by the clinical team and more latterly with input from key stakeholders that included patients and staff. Key statements included;

- Prevent ill health, improve well being and provide services that improve local health outcomes
- Deliver services that are responsive to the needs of our local communities and our commissioners
- Deliver financial duties and ensure the efficient use of resources
- Provide services that are equitable, accessible and of high quality
- Invest in the wider community interest
- To deliver high quality, integrated care that is closer to home and which meets individual needs

Evidence seen during our inspection indicated the practice was achieving these objectives and the whole team worked towards achieving the values described. This evidence was corroborated by patients who told us they felt the practice was well led and there was a positive culture of patient care.

Governance Arrangements

Governance arrangements were effective and supported transparency and openness. We saw the provider had a

Are services well-led?

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

range of governance policies and protocols that covered all aspects of the services it provided. We saw these were routinely reviewed and updated to reflect current guidance.

There was a clear staff list detailing individual areas of governance responsibility. The practice staff we spoke with were clear about what decisions they were required to make, knew what they were responsible for and fulfilled their role. For example, where a nurse was responsible for checking emergency medicine expiry dates this check was carried out; where fridge temperatures required monitoring to ensure travel vaccinations remained useable these were recorded in a daily log; and where security and safety of the premises was monitored we saw clearly documented records for these. The staff we spoke with told us the practice had a culture of auditing of day to day activities; the records and logs we saw confirmed these statements. However, whilst we were told about an oversight of these audits took place there were no records to support these statements.

Clear lines of responsibility for making specific decisions about the provision, safety and adequacy of the care provided at practice level were defined in the practice. The Practice Nurse we spoke with told us how they always referred patients back to the GPs where medical conditions changed and collectively they agreed the best course of action to involve and support the patient.

The practice ensured that any risks to the delivery of high quality care were identified and mitigated before they became issues which adversely impacted on the quality of care. For example, the provider had a business continuity plan which considered a detailed range of circumstances which might impact on service delivery. These were mitigated by a range of actions that were aimed to ensure the continuity of the service and contained a detailed list of contact telephone numbers where further advice could be gained. The practice had recently started planning for the retirement of one of the partners with a plan that recruitment would be initiated before their replacement became critical.

There were processes in place to ensure high quality care was being delivered. The GPs we spoke with told us they continually reviewed their patient lists and patient records were reviewed at each patient appointment. The nursing team were supervised and appraised by the GPs, patient care formed part of these reviews. Reception staff were observed by the practice manager to ensure patients were appropriately cared for on arrival to the practice. All staff had a responsibility to ensure patient safety was maintained and where concerns were observed in relation to vulnerable people, these were reported to relevant organisation including the local authority.

The practice placed importance on high quality data and information as this supported high quality decision making within the practice. We heard from the practice manager how they regularly maintained their quality outcome framework (QOF) (A voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients). information to ensure it was populated with the latest practice information. We saw the practice routinely gathered patient feedback from patients via suggestions and questionnaires and used this information to improve the practice. We heard from the practice manager how they used Clinical Commissioning Group (CCG) audits to inform their own governance reporting and practice improvement action plans. The provider's website was well maintained and informative and provided patients and potential patients with information about the practice and practice improvements. This meant the practice sought to use information to improve the practice.

Systems to monitor and improve quality & improvement

The practice was proactive in gaining patient feedback. A patient survey was carried out in February 2014 by the practice in conjunction with the patient reference group. The survey showed high levels of patient satisfaction with the services provided. For example 97% of the 96 patients who responded were satisfied they could see the GP or nurse of their choice; a similar percentage of patients were satisfied that waiting times were reasonable. Where less favourable comments were made, for example about the use of a 0844 number to contact the practice, we saw the practice had reverted to a 01308 number. We saw the results of the survey had been made available to all patients on the provider's website alongside the actions agreed as a consequence of the patient feedback.

Patient Experience & Involvement

Patients spoke highly of the practice and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. We heard how patients were supported by the practices carers group

Are services well-led?

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

and how this was highly valued. The provider had established a patient reference group which was used to inform the services development. We heard how this was due to be developed beyond a 'virtual' group to a group which met periodically. The people from this group we spoke with told us they felt their involvement was valued. All patients we spoke with spoke about the excellent service they received from all clinical and non-clinical staff.

Staff engagement & Involvement

We spoke with a range of staff including two GPs; the registrar GP; two practice nurses; the practice manager; dispensary staff; reception staff and the administrative team. All the staff we spoke with told us they felt involved in the day to day running of the practice as well as the longer term functions of the practice. We saw records which showed how staff were involved in staff meetings and saw how they discussed a range of practice issues. The minutes from these meetings showed how staff were involved in the planning around staff changes, registering new patients and planning for their travel clinic's vaccination programme.

We saw how many of the receptionist team had multiple roles in the practice, for example acting as a dispensing pharmacist, supporting the administration and carer group functions and assisting with phlebotomy. Staff in these roles told us this enabled them to pass on knowledge and observations to the clinical teams.

Learning & Improvement

The practice routinely considered improvements to their services and used feedback from the patient reference group to support changes. Where an incident occurred within the practice, we saw there were effective measures in place to learn from the incident. For example, where there had been a dispensing error with a medicine. We saw the incident had been investigated and heard from the practice manager how they and the dispensary manager reviewed dispensary procedures to reduce the risk of the incident recurring. We saw this information was passed on to staff at a subsequent staff meeting.

Where complaints were received about staff or other aspects of the practice, we saw the practice manager spoke with those involved and offered them support to improve their performance. Performance was also discussed and reviewed at annual staff reviews. This ensured that performance was reviewed and services were improved for patients.

During the feedback session following our inspection, we highlighted some of the aspects of the practice which could be improved. We found the provider and practice manager were receptive to out observation and in how they might consider small improvements to their service. They told us about constant reviews concerning the layout of the practice and how an extension had been built. They also explained about the considerations they made as a consequence of the patient reference group and opening hours. These examples showed the practice was keen to learn and improve so their services to patients could be generally accepted as excellent.

Identification & Management of Risk

The provider had risk assessed their practice and had put in place a number of policies and protocols which would minimise the risks to patients, their staff and the practice. Risks assessed included; the environment; patient safety; infection control; ensuring vulnerable patients were protected; the management of medicines; staff recruitment; record keeping; health and safety and managing emergency situations. We also saw the provider had a clear and detailed business continuity and disaster recovery plan. These showed the provider had considered future and current daily risks.

We saw from staff training records that these policies formed part of newly recruited staff induction programmes. The staff we spoke with demonstrated a good knowledge of these policies through the discussions we had with them. The provider and practice manager told us that where policies or procedures were amended, these changes were communicated to staff informally and at staff meetings to ensure they were implemented as soon as possible. The practice manager told us they monitored adherence to these policies.

Older people

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

Summary of findings

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We saw the practice supported residential care homes and nursing homes by making visits to patients living in these types of homes as well as visiting elderly patients in their own home. We saw how one GP had a responsible role for palliative care and how they supported elderly patients nearing the end of their life.

Our findings

The practice had a population profile very similar to the average population profile of the CCG for older patients. We saw the practice offered routine care to older patients, this included blood tests, blood pressure monitoring and general well man/woman consultations. We saw and heard how the provider had effective working arrangements with a range of other services such as local nursing and residential care services.

Older patients were seen as required or annually depending on the complexity of their needs by the clinical or community based nursing teams to review their medicines and health conditions. The practice also held clinics throughout the week for patients on medication for rheumatoid arthritis and blood clotting problems. This meant routine monitoring ensured older patients received the appropriate treatment and care when they needed it.

To help ensure patients remained safe at times of critical seasonal risk we saw seasonal flu vaccinations were routinely offered to older patients to help protect them against the virus and associated illness. We found the practice to be caring in the support it offered to older patients and there were effective treatments and on-going support for those patients identified with dementia or other mental health diagnosis. The practice was well led in in regard of improving the service provision for patients and their families or carers who received end of life care.

We found the practice to be responsive with the provision of a purpose built surgery which minimised difficulties with regard to accessibility and appropriate clinical areas. The building had been planned to provide ground floor consulting rooms and a spacious dispensary. A carer support group was also provided by the practice. There was a clear understanding from the leadership team of what the future of general practice would be in the area it served and the practice had responded to it proactively.

People with long term conditions

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

Summary of findings

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We saw how one GP had a responsible role for palliative care and how they supported patients with long term conditions nearing the end of their life. We heard about effective partnership working with other professionals as well as prompt referrals for patients with long term conditions.

Our findings

The practice offered routine care to patients with long term conditions which included blood tests, blood pressure monitoring, electro cardiography (ECG) and spirometry (to measure breathing) at the surgery. The practice had also purchased blood pressure monitoring equipment which they loaned to patients to help monitor their diagnosed condition. The practice offered nurse led chronic pulmonary obstructive disease (COPD) and diabetes clinics and patients were seen at least annually for their checks.

To help ensure patients remained safe at times of critical seasonal risk we saw seasonal flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness. Patients with long term illness were seen routinely depending on the complexity, by the clinical or community nursing teams to review their medicines and conditions. The practice also held daily clinics for patients on medication for rheumatoid arthritis and blood clotting. This meant patients with long term conditions were appropriately monitored and medication could be reviewed to ensure their health and wellbeing.

The practice held diabetic clinics with patients who had a diagnosis of diabetes being invited to attend these clinics. This meant that diabetic patients would be able to receive care, treatment and advice to reduce the risk of any complications arising with their condition or associated health conditions.

A regionally recognised carer support group was also provided by the practice to support carers of patients with long tern conditions. We found the practice to be caring in the support it offered to patients with long term conditions and the care they received was effective. The treatment pathways provided were monitored and kept under review by the clinical teams. The practice was responsive in

People with long term conditions

prioritising urgent care that patients required and the patients told us the practice was well-led in terms of improving outcomes for patients with long term conditions and complex needs.

Mothers, babies, children and young people

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

Summary of findings

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We heard about effective partnership working with community based nurses and midwifery services who supported mothers with babies and young children. We heard how the practice referred concerns about children in need to the local authority and how GPs worked with them to support children's wellbeing. We heard how a carers group was available to patients with a caring role.

Our findings

Mothers, babies, children and young people received routine care from the practice. Mothers attending the practice were seen for their initial antenatal assessment and then referred to the midwife who held clinics on site. Mothers were then seen again routinely for a postnatal check at the six to eight week stage. Babies were seen at the baby clinic within the practice where they were checked and given their first immunisations.

The practice worked closely with other professionals such as midwives and health visitors who provided childbirth preparation classes and support to first time mothers. The practice provided a responsive service, and made prompt appointments for mothers with babies and young children. The practice was well-led in relation to having a GP with lead responsibilities for children's safeguarding as well as for vulnerable adults. We found the practice was caring in its approach to mothers, babies, children and young people. We heard how they provided effective treatment and services which offering clinics at the practice and referrals to community based services to provide additional support.

Working age people (and those recently retired)

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

Summary of findings

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We saw the practice had listened to feedback from patients and how they increased the times the practice remained open to support the working age population and those recently retired. We heard how a carers group was available to patients with a caring role as well as lifestyle advice and information available to patients in this group.

Our findings

The working age population and those recently retired were offered routine care by the practice. The practice was open later from Monday to Thursday so that patients had the opportunity to make appointments with their GP after work. There was a telephone call back triage system in place for patients to request advice if they were unable to attend the surgery in the first instance.

We saw that flu vaccinations were routinely offered to vulnerable patients in the working age population. These were also available to those who had recently retired to help protect them against the virus and associated illness. The practice also offered travel vaccinations and travel advice on a private basis. There were effective monitoring services and clinics; the management team completed clinical audit cycles to evaluate outcomes for patients in this group.

Information and treatment was available for patients in this group regard of conditions likely to affect the working population. For example, information about mental wellbeing, lifestyle changes, managing stress, bereavement and psychological support.

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

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

Summary of findings

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We heard about effective partnership working with other professionals as well as prompt referrals for patients in vulnerable circumstances.

Our findings

The practice provided routine care to patients in vulnerable circumstances who may have poor access to primary care. The practice served a small community of travelling farm workers who used the practice. The practice provided support to patients with a diagnosed learning disability living in supported accommodation locally and also had patients who had drug or alcohol problems. The practice had systems for keeping in touch with these patients so that they had access when they needed it.

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

We found that the practice was caring about vulnerable patients such as the farm workers by providing access and support when there were issues around literacy. There was effective support from the practice for vulnerable patients and the practice was responsive in providing care in patients homes who found it difficult to attend.

People experiencing poor mental health

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

Summary of findings

Our inspecting GP spoke with the provider and the other GPs about patient groups as defined by the NHS and used as part of the Care Quality Commission's new methodology. They told us they recognised these groups as being important to the NHS and that they provided services to all of these groups. They told us they aimed to provide the same quality of service to all patient groups and that where a service worked for one group it may well be applicable to other patient groups. They cited their carers group as being a strong example of their approach. Other examples included vaccination services, diabetes services, extended opening hours and access to a GP of choice and gender through GPs holding individual patient lists.

We heard about effective partnership working with other professionals as well as prompt referrals for patients experiencing a mental health problem.

Our findings

We saw and heard how the practice offered routine care to patients experiencing a mental health problem. Patients were offered same day pre-booked and follow up appointments. Due to each GP holding patient lists in most circumstances it was possible to make appointments with the same doctor. Information and treatment was also available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support.

We found that the practice was caring in relation to patients experiencing poor mental health and the practice had effective procedures in place for undertaking routine mental health assessments. The practice was responsive in referring patients to other service providers for on-going support. We found the practice to be well-led with their approach in regard to identifying and managing risks to patients who may be experiencing poor mental health.

A carers support group which one of the practices administration team set up and managed was available to patients supporting someone with a mental health problem. The service was triggered when anyone in the practice identified a patient who had a caring role. The person's details were passed to the carer group co-ordinator; they then contacted the person to find out if they had any support or information needs. On-going support ranged from simple telephone conversations to referrals to support groups or services as well as group meetings.