The Grove Surgery

Quality Report

Fairmile Road
Christchurch
Dorset
BH23 2FQ
Tel: 01202 481192
Website: www.thegrovesurgery.co.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at The Grove Surgery on 20 October 2016. Overall the practice is rated as good.

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

- Involvement of other organisations, such as public health, the clinical commissioning group and Christchurch Health and Well Being Board were integral to developing services at the practice and beyond.
- There was a holistic approach to assessing, planning and delivering care and treatment to people using services. Examples included: an over 75s GP leading the inhouse specialist team (SMILE) delivering proactive support to vulnerable patients to avoid unplanned hospital admissions where ever possible.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. Examples included: Collaboration with an adult social care provider to provide dementia specialist care and step down beds in the area; Driving up quality by collaborating with seven other GP practices in a federation.
- A GP partner was the lead clinician on the local 'My Health, My Way' projectaiming to equip people with a long-term health condition with the skills and information that will help them to manage their condition and make informed choices about the support they require. Patients were able to access a range of support to suit them, including one-to-one coaching, telephone support, group work, on-line tools and structured support work.Patients experienced flexible services that aimed to provide choice and continuity of care. Self health management was promoted through a partnership with the patient aimed at helping them plan and achieve quality of life goals. Patients were enabled to be self directive of the timing of appointments, which was supported by proactive triage and management of their needs.There was an open and transparent approach to safety and an effective system in place for reporting and recording significant events.Staff assessed patients' needs and delivered care in line with current evidence based

Summary of findings

guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. Feedback from all 45 patients was strongly positive confirming they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns. The practice had good facilities and was well equipped to treat patients and meet their needs. 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.

- Governance systems were effective ensuring the practice focussed on patient health and social need outcomes.
- The leadership drove continuous learning and improvement at all levels within the practice. Safe innovation was celebrated.
- Integrated health and social care is strongly advocated and the practice has driven innovation in the integration of community services in Christchurch.Examples included:engagement with the community to discuss and agree health and social care priorities for Christchurch.Educating citizens in the community about early identification of malnutrition and what to do to seek help for vulnerable people.Leading the development of a hub approach with a federation of seven other GP practices to provide onsite and co-located secondary health and social care services.Patients benefitted from these initiatives by being better informed, only attending the practice when absolutely necessary and having access to a wider range of services and appointments across the Hub.

We saw one area of outstanding practice:

The practice had set up a pilot with local schools in the last 12 months providing responsive GP assessment service, whereby a child/young person was guaranteed a same day appointment to determine their fitness to attend school. Early data indicated that school absence rates had improved by 90% as a result of this pilot. In addition the practice had established a joint volunteer initiative, in which the practice helped train volunteers to support patient families with a child/young person with mental health needs. Families who could be vulnerable and isolated benefitted from the befriending support from volunteers.

The areas where the provider should make improvement are:

Safety net systems needed further development and should include the setting up of system to ensure that all urgent referrals to secondary services are successfully received.

Review audit processes to ensure multiple cycle audits are undertaken to measure service improvement.

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 things went wrong patients received reasonable support, truthful information, and a 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.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- The clinical audit processes needed to be reviewed to ensure multiple cycle audits were undertaken to measure service improvement. 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 other health care professionals to understand and meet the range and complexity of patients' needs.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The 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. The practice promoted self management for patients enabling them to tailor their appointments, for example having access to appointments between 10 and 20 minutes or more in length.
- There was GP triage of all contacts to support patients making the most appropriate choice of appointment, by phone, in person, same day and with the right clinical staff.
- The Grove Surgery provided GP leadership and funded a specialist nursing team supporting vulnerable patients who were over 75 years. The aims of the team included: rapid assessment of patients with cognitive changes to facilitate early diagnosis of dementia. Unplanned hospital admission avoidance for patients wherever possible and carer support.
- Patients providing written and verbal feedback at the inspection were strongly positive about access to appointments.
- The practice had relocated to new purpose built premises, which were well equipped to treat patients and meet their needs. The practice had purposefully relocated onto the same site as secondary hospital and adult social care services to facilitate the development of future integrated services.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The Grove Surgery provided a positive experience for GP registrars. The practice had achieved the Centre and training excellence award as a result of feedback from trainees about the support, approachable and dynamic leadership team.
- Succession planning and recruitment of new staff was successful. This was illustrated by examples: there had been a high level of interest expressed by GPs to cover an additional five GP sessions recently created at the practice. The practice attracted new staff when staff retired or left.

Summary of findings

- There was a clear leadership structure, which incorporated business management for the development of the practice. Examples included co-locating the new premises on the same site as secondary and adult social care services.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. Audits were in progress when we inspected but had not been completed. The practice had a number of policies and procedures to govern activity and held regular governance meetings, which were inclusive with all staff groups represented by senior 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 notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- Involvement of other organisations, such as public health, the clinical commissioning group and Christchurch Health and Well Being Board were integral to developing services at the practice and beyond. The practice proactively sought feedback from the citizens, some of whom were patients in the community, staff and patients, which it acted on. The patient participation group was active prior to the premises move and planning further meetings.
- There was a strong focus on continuous learning.
- The GP partners demonstrated a strong commitment to integrating health and social care for people in Christchurch. This was illustrated by several pilots initiated at the practice, which had secured funding and development of services within the locality. Examples included: a proactive project to improve school attendance for young patients with health conditions. Early recognition of malnutrition for vulnerable people and raised public awareness of where to ask for help. Advocating for improved access to secondary mental health services for children and adolescents across the Christchurch locality.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

- The Grove Surgery had double the number of patients over 75 years (16.6% of the practice list) compared with the national average of 7.7%.There is a higher prevalence of chronic disease and life limiting illness for patients, with associated risks of isolation and vulnerability in old age. The SMILE (Self Management in the Local Environment) team was employed by the practice to support these patients. A dedicated over 75's GP was responsible for overseeing the support of vulnerable patients by a nurse and two healthcare assistants. Patients experienced responsive and well managed support, the team provided home visits and proactive monitoring to avoid unplanned hospital admissions where ever possible. We saw anticipatory care plans were in place for all these patients which were being monitored by the SMILE team resulting in a higher level of continuity of treatment and care for these patients.
- The practice had a named member of staff as the carer lead who was proactive in identifying any carers, signposting and providing support to them where needed.
- The practice had a clear overview of the priorities for older people living in Christchurch. GPs had worked with the community through the Health and Wellbeing Group to encourage a provider to build an adult social care home specialising in dementia, which was a gap in provision for an ageing population. A closer relationship with the home had been established resulting in improved levels of clinical support when required.

People with long term conditions

Good

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

- Patients experienced flexible services that aimed to provide choice and continuity of care. Self health management was promoted through a partnership with the patient aimed at helping them plan and achieve quality of life goals – 'My Health, my way'. Patients were enabled to be self directive, setting the timing of appointments, which was supported by GP triage and prioritisation of needs accordingly.

Summary of findings

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was above the national average. For example, 94% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (national average 87.4%).
- Longer appointments and home visits were available when needed and triaged by a duty GP.
- 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.

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practice's uptake for the cervical screening programme was 83%, which was above the CCG average of 77% and the national average of 82%.
- 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.

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 including.

Summary of findings

- Patients were able to access appointments on-line and have telephone consultations between 6.30pm and 7.30pm every weekday.
- Patients could receive SMS text prompts for appointments if they registered for this service.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- Patients had flexibility and choice about the length of appointments, including identification of who they wanted to support them. For example, some patients with learning disabilities received support from the learning disability specialist nursing team at appointments for women such as cervical screening.
- Vulnerable patients who were at risk due to social isolation and with complex needs received proactive support from the in-house SMILE team (Self management in the local environment).Early interventions such as befriending and additional social care were put in place to help them manage their health conditions avoiding hospital admission wherever possible.
- The practice had initiated a Malnutrition Project, which educated citizens in the community to recognise and seek early intervention from the SMILE team to provide support for people at risk of numerous health problems.
- Vulnerable families and children were receiving support through initiatives led by the practice. These included: awareness of and action to reduce the risk of abuse in vulnerable children and young people. Supporting children and young people who were vulnerable due to health conditions to increased absence from school. Through a joint venture with schools, the practice had set up a responsive GP assessment service whereby a child/young person was guaranteed a same day appointment to determine their fitness to attend school. Early data indicated that school absence rates had improved by 90%. A joint volunteer initiative, in which the practice helped train volunteers to support families with a child/young person with mental health needs.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

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

- 88.9% of patients diagnosed with dementia had their care reviewed in a face to face meeting in the last 12 months, which was comparable to the national average of 85%.
- Patients with potential early signs of dementia were able to access rapid assessment leading to earlier diagnosis and identification of support through the in-house SMILE team (Self management in the local environment).
- Performance for mental health related indicators was above the national average. For example, 96% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (national average 88.5%)
- 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.
- The practice had told and provided information for patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- 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.

Summary of findings

What people who use the service say

The national GP patient survey results were published on January 2016. The results showed the practice was performing in line with local and national averages. Two hundred and fifteen survey forms were distributed and 116 were returned. This represented approximately 2.2% of the practice's patient list. Results from the survey showed;

- 97% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 89% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 93% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 91% of patients said they would recommend this GP practice to someone who had just moved to the local area compared to the national average of 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 33 comment cards which were all positive about the standard of care received. Staff were described as being efficient, friendly and caring. Patients had confidence in the treatment and care they were receiving.

We spoke with 12 patients during the inspection. The majority of patients said they were satisfied with the care they received and thought staff were approachable, committed and caring. Between September 2015 and September 2016, 66 patients completed surveys as part of the Friends and Family test. During this period on average 90% (60) of patients were extremely likely or likely to recommend Grove Surgery to their friends or family.

The Grove Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and an expert by experience.

Background to The Grove Surgery

The Grove Surgery is situated in a new purpose built practice at Christchurch Hospital. The practice provides general medical services in Christchurch, Dorset. The area covered incorporates the coastal town, attracting temporary residents on holiday during the Summer months.

There is low social deprivation in the area. At the time of the inspection, there were 5,232 patients on the practice list and the majority of patients are of white British background. The Grove Surgery has nearly double the number of patients over 65 years (43.9% of the practice list) compared with the national average of 27.2%. There is a higher prevalence of chronic disease and life limiting illness for patients, with associated risks of isolation and vulnerability in old age. All of the patients have a named GP.

The practice has two GP partners and two salaried GPs (two male and two female). The practice has a higher ratio of GPs avoiding the need to use GP locums. The nursing team consists of three female practice nurses. One of the nurse holds prescribing qualifications enabling them to treat patients with minor illness. All the practice nurses specialise in certain areas of chronic disease and long term conditions management.

The Grove Surgery is an approved training practice. Two GP partners are approved as trainers. The practice normally provides placements for trainee GPs and F2 trainees (qualified doctors in the second year of their foundation training). There were two GP registrars working at the practice when we inspected.

The practice has a specialist team (Self Management in Local Environment) to support vulnerable patients, provide home visits and proactive monitoring to avoid unplanned hospital admissions where ever possible. It comprises of a female nurse and two female health care assistants (HCA). One of the HCA's role focusses on ensuring patients who may have dementia are appropriately assessed and supported.

The practice is open 8.30am to 6.30pm Monday to Friday in line with local contractual arrangements. Phone lines are open from 8.30am to 6.30pm, with the out of hours service picking up phone calls outside of these times. GP appointment times were available morning and afternoon every weekday. The practice has a flexible appointment length and patients are encouraged to book an appointment to suit their needs. Extended opening hours are provided: Monday, Thursday and Friday. Early morning appointments are available from 7.30am every Monday and Friday, and evening appointments are available every Thursday from 6.30pm until 7.30pm. Telephone appointments are available Monday to Friday by arrangement. Patients are able to book routine appointments on line up to five weeks in advance.

Information about opening times are listed at the practice, on their website and in the patient information leaflet.

Opening hours of the practice are in line with local agreements with the clinical commissioning group. Patients requiring a GP outside of normal working hours are advised to contact the out of hours service provided by the out of hours service in Dorset.

Detailed findings

The practice has a General Medical Service (GMS) contract.

Why we carried out this inspection

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 20 October 2016.

During our visit we:

- Spoke with a range of nine staff (GPs, practice manager, practice nurse, IT manager, reception and administrative staff) and spoke with 12 patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed 33 comment cards where patients and members of the public shared their views and experiences of the service.
- Reviewed four emails from patients who were members of the patient participation group.

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

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

We also looked at how well services were provided for specific groups of people 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 CQC 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 incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, following the investigation of an incident the practice reviewed its criteria for safe prescribing of the combined oral contraceptive pill (COC) to ensure all risk factors were reduced for patients. The practice changed its systems and we were shown the new standardised template being used to ensure the patient's blood pressure, body mass index and smoking status was checked prior to prescribing the COC.

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. These arrangements reflected relevant legislation and local requirements. 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 protocols being followed.Staff described the actions taken safeguard individuals when a vulnerable patient was seen to have significant weight loss which could make them at risk of malnutrition.
- Staff training logs showed that all staff had received safeguarding training.Minutes of meetings and discussion with staff demonstrated that staff had completed training with the GP Safeguarding lead and were appropriately following procedures.All GPs were trained to child protection or child safeguarding level three.
- A notice in the waiting room advised patients that chaperones were available if required. Information sent by the practice prior to the inspection demonstrated chaperone training had been provided for staff who might be expected to undertake the role. Staff explained the chaperone policy which only permitted staff who had received training and had a DBS check would undertake this role (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. Annual infection control audits were undertaken, including twice yearly handwashing audits. We saw evidence that other action was taken to address any improvements identified by audits. For example, following the move to the new premises, contracts were being negotiated to ensure baby changing and sanitary waste was disposed of correctly.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines

audits, with the support of the local clinical commissioning group (CCG) medicines optimisation team, to ensure prescribing was in line with best practice guidelines for safe prescribing.

- Blank prescription forms and pads were securely stored and systems had been reviewed with increased vigilance of their use. One of the nurses was in the process of completing an advanced course to become an independent prescriber, but was not yet able to prescribe medicines for specific clinical conditions. Arrangements were in place for this nurse to receive mentorship and support from the GPs for this extended role during the course and once qualified. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. We saw nurses followed patient specific prescriptions or directions from a prescriber, for example, regarding travel vaccines.
- We saw records demonstrating that practice was in regular contact with the medicines optimisation team at the Dorset CCG.
- We reviewed two 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.

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 with a poster in the reception office which identified local health and safety representatives. The practice had an up to date fire risk assessment with clear evacuation information throughout the building for staff to follow.
- 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).
- All electrical equipment was checked throughout the site when the new premise was ready for occupation in May 2016 to ensure the equipment was safe to use. For example, the practice supplied the Care Quality Commission (CQC) with evidence of building safety, including a fire risk assessment at the point of registration in August 2016. Certificates seen demonstrated that clinical equipment was checked to ensure it was working properly.
- 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 enough staff were on duty and arranged leave around these requirements. GPs told us the practice had invested in employing a higher ratio of staff to patients, so was able to cover all leave without having to use locum staff. Salaried GPs explained their responsibilities as the duty GP, which included monitoring any patient results to cover another GP when they were on leave. We looked at electronic records, which demonstrated there were no patient results outstanding requiring review by a GP.

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, which were for patient use were in date and stored securely. The practice held some emergency medicines for training use only, which were clearly labelled as such.
- 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.
- Safety net systems were in place but needed further development.For example, following a significant event the practice had made some changes around urgent

Good

Are services safe?

referrals.Any patient being referred for an urgent appointment was asked to contact the practice if they had not received this within 10 days.During feedback, we highlighted that the practice did not have a formal system to ensure that an urgent referral to secondary services had been successfully received.The practice told us they would implement this immediately.

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 patients' needs. For example, the practice worked closely with the midwifery team and had implemented national guidelines covering the continued monitoring of any female patient experiencing gestational diabetes (diabetes occurring during pregnancy).
- 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 100% of the total number of points available.

This practice was not an outlier for any QOF (or other national) clinical targets. We looked at the exception reporting for the diabetes and mental health registers of patients. 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).The practice QOF exception reporting was lower when compared with the clinical commissioning group (CCG) and national averages. For example, for diabetes the practice exception reporting of patients with diabetes, on the register, with a record of a foot examination and risk classification was 6.4% versus the CCG and national averages of 10.6% and 9%.

Data from 2015/16 showed:

- Performance for diabetes related indicators was above the national average. For example, 94% of patients on the diabetes register had a record of a foot examination and risk classification within the preceding 12 months (national average 87.4%).
- Performance for mental health related indicators was above the national average. For example, 96% of patients with schizophrenia, bipolar affective disorder and other psychoses had a comprehensive, agreed care plan documented in the record, in the preceding 12 months (national average 88.8%)

There was evidence of quality improvement including clinical audit.

- There had been seven clinical audits commenced in the last year, none of these were completed audits as they were in the first part of the cycle.However, improvements had been made.Ongoing monitoring was planned for the second cycle of the audit.For example, following a significant event the practice carried out an audit and found 35 female patients had a repeat prescription for the Combined Oral Contraceptive (COC). All 35 patients had been taken off the repeat prescription system. Out of a total of 256 female patients on this medicine the practice found 88 having no record of their Body Mass Index (BMI) in the previous year. This was added to the standard template as a mandatory field to complete when assessing a patient as to their suitability to be prescribed the COC.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.
- Findings were used by the practice to improve services. For example, the practice had carried out an unused appointments audit to assess demand and capacity over a six month period from October 2015 to March 2016. The audit showed 358 unused GP appointments and 263 unused nurse appointments in the timeframe. The practice determined the results suggested there was good availability of appointments, with 5% "slack in the system" though downwards trend over the period. The audit was due to be repeated for the timeframe October 2016 to March 2017 to assess whether patients had access to sufficient appointments following the move of premises.

Good

Are services effective?

(for example, treatment is effective)

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 reviewing patients with long-term conditions. Nursing staff manage long term conditions and hold advanced qualifications. The practice hosted a nursing forum for all practice nurses in the locality. This enabled staff to network with peers across the locality, update and develop shared ways of working.
- The practice provided us with information about staff training prior to the inspection.All staff had received basic life support training, the role and responsibilities of chaperones, fire safety and the Mental Capacity Act 2005. Arrangements had been set up for staff to access and make use of e-learning training modules, which when interviewed staff confirmed they were using.
- 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; for example, ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. There was a rolling schedule of appraisals taking place and all staff had received an appraisal in the last 12 months.

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.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

The practice had a proactive approach to managing patients who were over 75 year old. They had achieved funding for a specialist over 75s GP to manage the self management in local environment (SMILE) team and monitor the needs of all elderly and frail patients. Elderly and frail patients registered at the practice were supported the SMILE team, employed at the practice. Staff worked together and with other health and social care professionals 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. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs. Plans seen showed this inhouse service was expanding from January 2017. In conjunction with the Royal Bournemouth and Christchurch Hospital the practice was due to manage the care of patients over 75 across a number of practices with a whole time equivalent GP managing a list of 500 patients with back-up from secondary care and community teams.

The midwifery team ran dedicated clinics for pregnant women within the practice. Representatives from this team gave positive feedback about the way GPs communicated important information about patients with them. They told us GPs were very supportive in concerning situations. For example, a GP supported the midwives recommendation and liaised with secondary services to ensure a female patient was seen in a sexual health clinic.

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. For example, they shared examples of where they had taken decisions in the best interests of patients. We saw templates which had been developed and prompted staff to assess a patient's capacity.

Good

Are services effective?

(for example, treatment is effective)

When providing care and treatment for children and young people, 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 patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation.Patients were signposted to the relevant service.
- Practice nurses told us that they worked closely with learning disability nurse specialists to support patients with learning disabilities to lead healthier lives.A rolling programme of annual health checks was underway and patients had written health plans.
- Smoking cessation advice was available from practice nurses and information provided about a local support group.

The practice's uptake for the cervical screening programme was 83%, which was comparable with the CCG average of 83% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and in easy read format for those with a learning disability. They ensured a female sample taker was available. The nursing team audited the effectiveness of the cervical screening carried out at the practice. This enabled the team to identify if any additional training was required. Four hundred and seventy four smears were carried out in two year period. Of these 474, a total of 4 inadequate smears (0.01%) were seen, shared between three of the smear takers. No further training requirements were identified by the practice and the audit was due to be repeated June 2018, or earlier if the inadequate smear rate rose.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. 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.

Childhood immunisation rates for the vaccines given were comparable to CCG averages (under two year olds ranged from 90% to 93% and five year olds from 91.8% to 97.4%. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 90% to 93% and five year olds from 90% to 93%.

Patients had access to appropriate health assessments and checks. Health checks for new patients and NHS health checks for patients aged 40 to 74 were offered. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

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 saw 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. The practice had a confidentiality agreement, which staff followed. and had been developed across all three practices at the medical centre.

All of the 33 patient Care Quality Commission comment cards we received were 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 12 patients who were attending the practice for appointments. The majority of patients told us they were satisfied with their care, describing staff as very thorough.

We spoke with a member of the patient participation group (PPG) at the practice. They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was in line with and above the clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 96% of patients said the GP was good at listening to them compared to the CCG average of 92% and the national average of 89%.
- 96% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%
- 94% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 88% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 98% of patients said they found the receptionists at the practice helpful compared to the CCG average of 91% and the national average of 87%

Care planning and involvement in decisions about care and treatment

In total, 45 patients told us in writing or in person 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 from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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 above national averages. For example:

- 95% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 94% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

Good

Are services caring?

- 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.
- Information leaflets were available in easy read format.
- Patients with long term conditions and over 75's had anticipatory care plans in place, which had been agreed with them.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website.

The practice's computer system alerted GPs if a patient was also a carer. The practice had been proactive in identifying carers since 2003 and prompted new patients to identify this when registering at the practice. At the point of inspection, the practice had identified 117 patients as carers (approximately 2.25% of the practice list). The Grove Surgery had a carers pack which it gave to anyone identifying themselves in this role. The practice had a named member of staff who was the carer lead who was mentoring another member of staff to undertake this role in another practice. The carers lead role included identification of carers, signpost and provide support to them were needed. Written information was displayed in the waiting room and on the practice website to direct carers to the various avenues of support available to them. This included dates of carers forums

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The practice worked closely with a local befriending charity to support patients who could be vulnerable due to isolation through limited social networks.

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 Dorset clinical commissioning group (CCG) to secure improvements to services where these were identified. We saw several examples of these being implemented by the practice providing influence across the locality:

- Peoples individual needs and preferences were central to the planning and delivery of tailored services.This was illustrated by the operating philosophy at the practice to promote self management for patients through the 'My Health, my way' project.GPs individualised care for patients, by covering healthy living, managing health and social care concerns and improving quality of life through social networks during discussions with them.
- The Grove Surgery had double the number of patients over 75 years (16.6% of the practice list) compared with the national average of 7.7%.There is a higher prevalence of chronic disease and life limiting illness for patients, with associated risks of isolation and vulnerability in old age. The SMILE (Self Management in the Local Environment) team was employed by the practice to support these patients. A dedicated over 75's GP was responsible for overseeing the support of vulnerable patients by a nurse and two health care assistants.The team provided home visits and proactive monitoring to avoid unplanned hospital admissions where ever possible working closely with other agencies to provide support and increasing contact with patients. We saw anticipatory care plans were in place for all these patients and were being monitored by the SMILE team.
- 19% patients registered with the practice were under 18 years old.A GP school attendance project was set up between GPs at the practice and the public health team. Pupils with poor attendance related to health conditions had been identified and put onto a scheme whereby the practice guaranteed a same day appointment for assessment.The project had yet to be formally evaluated when the inspection took place, however early data from local schools indicated that the majority of pupils in this scheme had improved attendance to 90% of the time.GPs told us the practice had provided 14 additional consultations for children and young people during a six month period of the project.
- Services were flexible and provide patients with choice to ensure continuity of care.This was illustrated by: a flexible appointment structure enabling patientsto determine the length of time needed for an appointment, which could be more than 20 minutes in length.
- There were longer appointments available for patients with a learning disability. A named member of staff working was responsible for recalling patients for their annual appointments.
- A duty GP provided additional backup for any patient contact and was responsible for triaging patients needs. Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- The practice hosted additional services to be held there. For example, patients were able to access private chiropractic services for musculoskeltal complaints. The practice had negotiated a lower cost for patients paying for treatments and was providing funding for patients in need who had limited finances who may not otherwise be able to access this service.
- Secondary care services were brought closer to home and run jointly by practice and hospital based specialists. For example, a monthly diabetic clinic was run at the practice with the hospital nurse specialist for any patients with complex needs. This had facilitated the upskilling of practice nursing staff who were able to initiate treatment changes to insulin for patients where needed. Further services were planned and due to start in November 2016 run by the federation that Grove Surgery was part of.
- The practice had relocated to new premises which were co-located on the same site as secondary services and a newly built adult social care home. Patients were able to access the nearby hospital based phlebotomy service and clinics all on the same site. The premises were purpose built. All patient areas were located on the ground floor with disabled facilities, a hearing loop and translation services available.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- Reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.

Access to the service

The practice was open 8.30am to 6.30pm Monday to Friday, in line with local contractual arrangements. Phone lines were open from 8.30am to 6.30pm, with the out of hours service picking up phone calls after this time. GP appointment times were available morning and afternoon every weekday. Extended opening hours were provided: early morning appointments were available from 7.30am every Monday and Friday, and evening appointments were available every Thursday from 6.30pm until 7.30pm. Telephone appointments were available Monday to Friday by arrangement.

In addition to pre-bookable appointments that could be booked up to five weeks in advance, urgent appointments were also available for patients that needed them.

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

- 85% of patients were satisfied with the practice's opening hours compared to the national average of 76% (CCG average 78%)
- 96% of patients said they could get through easily to the practice by phone compared to the national average of 73% (CCG average 84%).

The practice had carried out an audit to assess patient demand and appointment capacity over a six month period from October 2015-March 2016. The audit showed 358 unused GP slots and 263 unused nurse slots in the timeframe reviewed. The practice told us the results suggested there was good appointment availability. This was borne out by the feedback we received at the inspection with patients telling us they were able to get appointments when they needed them. The practice planned to carry out a further audit looking at the period October 2016 to March 2017 to assess whether they were continuing to offer sufficient availability following the move.

The practice had a duty GP system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system.Posters were displayed and a summary leaflet was available in the waiting room.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way and handled with openness and transparency when dealing with the complaint. Lessons were learnt from individual concerns and complaints, which were regularly discussed at meetings. For example, the practice had altered procedures to ensure that patients were screened for potential gestational diabetes during pregnancy in line with national guidelines.

Are services well-led?

Good

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

Our findings

Vision and strategy

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

- The Grove Surgery aimed to provide patients with high quality integrated care where they were in partnership with GPs to achieve this. All staff demonstrated these values and were proud of their person centred approach.
- The practice strategy and supporting objectives were stretching, challenging and innovative. There were several examples of this, including the approach taken in recognition of families with additional need of support who were falling short of thresholds for referral to child mental health services. Innovative communitarian initiatives included joint working with the Health and Well Being Group and local schools to obtain funding for a family support scheme and GPs providing training for the volunteers involved in this. Vulnerable families benefitted from support from befrienders.
- The Grove Surgery had achieved the Training Centre of Excellence award in 2016 and attracted interest from previous trainee GPs interested in positions at the practice.
- The Grove Surgery had consistently grown in list size since its inception as a practice, starting out with no patients to 5232 in October 2016. GP partners had decided to increase the GP to patient ratio well above that required.The practice was recruiting new GPs to fulfil a further five sessions.Once fulfilled, GPs would have a patient list size of 1,500 patients increasing their time to monitor patient needs and to increase appointment capacity to cope with further planned list expansion.
- Strategic plans to integrate and work as a hub drove the decision to relocate in May 2016.The new premises was co-located with the hospital and an adult social care home specialising in care of people with dementia. A suite of four clinical rooms within the practice was run by the federation of eight GP practices which Grove Surgery was part of.In November 2016 several integrated healthcare clinics were planned to start there providing podiatry, leg ulcer management and specialist nurse led clinics for patients with multiple sclerosis and parkinson's disease.

Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. For example, all of the GP partners had lead clinical roles and supported nursing staff specialising in these areas.
- Practice specific policies were implemented and were available to all staff. The practice was working in a federation with a group of seven other practices to develop common policies and procedures. This approach would help ensure a consistent approach to service delivery where patients attended another location to receive services.
- A comprehensive understanding of the performance of the practice was maintained. The practice had a lead GP partner with responsibility for monitoring quality, including patient outcomes through the Quality Outcome Framework (QOF).
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. However, this needed to be reviewed to increase opportunities for monitoring and improvement of quality and identify risk. The practice had a number of policies and procedures to govern activity and held regular governance meetings, which were inclusive with all staff groups represented by senior staff.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. All of the staff we spoke with told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

Are services well-led?

Good

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

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.In examples seen, we found responses to patients were compassionate and honest.Staff keenly reflected on the learning from these and had implemented changes that would benefit patients.
- The practice 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. There was a rolling schedule of meetings held weekly, monthly and every quarter.These included patient care such as hospital admission avoidance for vulnerable patients and end of life care.GP partners met regularly as a team with the practice manager and practice discuss all business matters, including finance. Minutes were kept and important information was disseminated through other team meetings for administrative and reception staff and the nursing team.
- 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 and supported in doing so.
- 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

Innovative approaches were used to gather feedback from people who use services, the public and other stakeholders.

- Bimonthly Christchurch Health and Wellbeing Board meetings were chaired by one of the GP partners, which facilitated discussion and agreement of shared community priorities for health and social care.Some of these were attended by patients of the practice. Examples included: addressing gaps in supporting children and young people with mental health needs; educating all citizens about recognising the early signs of malnutrition in a vulnerable person and how to seek help for them; addressing social care gaps with the building of a care home specialising in dementia care.These community priorities were seen being actioned through the plans and projects being developed at the practice.
- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG had 70 core members who had yet to meet again since the practice moved to its new premises. A representative from the group told us had been fully involved in the plans, move to the new premises and service developments.
- The practice had gathered feedback from staff through meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. The practice demonstrated it valued staff by funding training to develop their skills, for example funding an idependant prescriber course for a practice nurse.

Continuous improvement

The leadership drove continuous learning and improvement at all levels within the practice. Safe innovation was celebrated and we saw several examples of this:

The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The concept of self-management was incorporated into every patient during consultations; examples seen included: the practice initiated the setting up of the 'Self

Are services well-led?

Good

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

management in local environment' (SMILE) team in 2007 to proactively assess, monitor and support patients with complex health and social care needs; the introduction of a named senior GP with dedicated time to manage over 75's care and support.

The Grove Surgery was working with seven other practices in the locality in a federation to increase collaboration and creation of shared policies and procedures.

The Grove Surgery had close links with the universities as a training practice. Two GPs were approved GP trainers,. There was a regular intake of GP registrars at the practice. Educational meetings were held monthly which any member of staff could attend. These drew learning from practice data, national guidance and research papers which were then discussed and led to projects at the practice. The aim of this was to enhance patient care and treatment.