Leybourne Surgery

Quality Report

1 Leybourne Avenue
Ensbury Park
Winton
Bournemouth
Dorset
BH10 6ES
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Website: www.leybournesurgery.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?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Leybourne Surgery 1 Leybourne Avenue, Ensbury Park, Winton, Bournemouth, Dorset, BH10 6ES on 28 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring and responsive services. It was also good for providing services for older people, people with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia). It required improvement for providing well led services.

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

• Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.

- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- In 2014 national patient survey 97% of respondents said they had confidence and trust in the GP treating them. This was slightly higher than the national average
- Information about services and how to complain was available and easy to understand.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- At the time of our visit the practice did not have a dedicated practice manager. In order to fulfil the business needs of the practice the senior partner employed locum GPs to manage patient appointments. The senior partner was also working extended hours to fulfil their duties both as the practice manager and GP.

The areas where the provider must make improvements are:

The management hours and associated responsibilities must be reviewed to ensure the on-going governance of the quality and safety of the practice.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It 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. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

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

Are services well-led?

The practice is rated as requires improvement for being well-led. It had a vision and a strategy but not all staff was aware of this and their responsibilities in relation to it. There was a documented leadership structure and most staff felt supported by management but at times they were not sure who to approach with issues. The practice had a number of policies and procedures to govern activity. Governance meetings were held every six months. The practice proactively sought feedback from patients and had an active patient participation group. All staff had received inductions but not all staff had received regular performance reviews or attended staff meetings and events.

Requires improvement

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

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

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

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. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

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). Data supplied showed that 86% of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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

Summary of findings

What people who use the service say

We received five completed patient comment cards and asked six patients for their views at the time of our inspection visit. These included older patients, mothers with babies, vulnerable patients and patients of working age.

All of the patients we spoke with and who completed Care Quality Commission comment cards were very positive about the care and treatment provided by the GPs and nurses and other members of the practice team. Everyone told us that they were treated with dignity and respect and that the care provided by the GPs, nursing staff and administration staff was of a very high standard. Comments included reference to the practice being caring, staff being friendly, polite and willing to help.

The practice had an active patient reference group who improved communication between the practice and its patients. This group was a way for patients and the practice to listen to each other and work together to improve services, promote health and improve the quality of care.

Results of surveys were available to patients on the practice website alongside the actions agreed as a result of the patient feedback.

We also looked at the results of the 2014 GP patient survey which was published in January 2015. This is an independent survey run behalf of NHS England. The survey showed that the practice achieved better than average results for the local area and nationally, these results included;

• 79% of respondents said the last GP they saw or spoke to was good at giving them enough time. This was slightly lower that the National average.

• 97% of respondents said they had confidence and trust in the GP treating them. This was slightly higher than the national average.

Feedbacks posted by patients on the NHS Choices website were mainly positive although there was a negative comment about the way in which a GP had spoken to a patient. The practice had replied to the feedback and apologised to the patient.

Areas for improvement

Action the service MUST take to improve

The management hours and associated responsibilities must be reviewed to ensure the on-going governance of the quality and safety of the practice.

Leybourne 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 and a practice manager specialist advisor.

Background to Leybourne Surgery

Leybourne Surgery is located in the north of Bournemouth. The practice occupies a converted house. A local pharmacy is situated opposite the building.

The practice provides a range of primary medical services to approximately 3,900 patients. Patients are supported by two GPs, one male and one female. One partner works nine sessions per week and the other partner works six sessions per week. The practice has two nurses, one phlebotomist (someone who is trained to take blood samples) and one health care assistant who also acted as a second phlebotomist. The senior partner is the registered manager and also performs the role of practice manager and the practice has seven administration and reception staff.

The practice is a member of the Dorset Clinical Commissioning Group (CCG) and holds a general medical services contract.

The practice is open from 8am to 6:30pm Monday to Fridays. The practice closes at lunchtime from 12.30 to 13.30 but the telephone is manned during this period.

An evening surgery is held on Mondays from 6.30pm to 8.30pm. This is for pre-booked appointments only. During this period the practice telephone is answered by 111/out of hour's service.

When the practice is closed the practice is covered by South West Ambulance Service Trust out of hour's service.

Patients are seen by appointment during surgery hours and reception staff are available to answer calls from 8am onwards. Patients are asked to telephone after 9.30am to make a routine appointment or request a home visit, unless the matter is urgent.

Patients are able to speak with a GP, practice nurse or district nurse and this is usually without the need for a call back being made by the relevant health professional. If necessary the health professional will be contacted via a pager or mobile phone to respond more quickly to the message. Time is made available in GPs morning surgeries to respond to requests for telephone consultations if they are unable to respond immediately to a request.

We carried out this announced inspection at, Leybourne Surgery, 1 Leybourne Avenue, Ensbury Park, Winton, Bournemouth, Dorset, BH10 6ES.

The practice was previously inspected by the Care Quality Commission as part of the pilot for inspecting GP practices in June 2014. At that inspection the practice did not meet the required standards in one area: requirements relating to workers. At this inspection we were able to see that appropriate action had been taken by the practice to meet the required standard in this area. At the previous inspection the practice was not given a rating as at that time ratings were not part of the inspection process.

Why we carried out this inspection

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

Detailed findings

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. This 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.

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.

How we carried out this inspection

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

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

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

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them.

The population groups 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)

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, the practice had developed a Leybourne Surgery significant event reporting form which was completed by staff if required. We saw the form had a unique reference number and when completed all relevant information such as actions taken, outcomes, learning points and follow up reviews of actions taken when needed, were documented.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the registered manager, who was the senior GP partner. The senior partner showed us the system used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. An example seen was where a patient had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

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

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

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

The practice used codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care

professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff did not undertake chaperone duties.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance.

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy which had been reviewed and updated in May 2015.There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the procedures and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and findings of the audits were discussed at practice meetings. The last audit was conducted in May 2015 and hand washing protocols were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with liquid hand soap, sanitising hand gel and hand towel dispensers were available in treatment rooms.

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was 2014. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employment in the form of references, evidence of qualifications and registration with the appropriate professional body.

At the previous Care Quality Commission inspection this was an area that this practice was not meeting the

standards required. The practice had not conducted appropriate criminal records checks on staff prior to their employment through the Disclosure and Barring Service (DBS).

We were told that no new staff had been employed since the last inspection and saw that the recruitment policy had been updated to ensure that the required checks would take place.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The senior partner showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements. However there was not a practice manager employed at the practice and we found the reduced management hours available had impacted on the running of the practice.

The practice used a number of locum GPs on a regular basis. The practice has a list of about 10 locums who were booked up to eight months in advance to cover the annual leave of the two partner GPs as well as to cover the lead GP partner's clinical sessions to enable them to undertake administrative duties required in running the practice. The locums were all checked by the senior partner and we saw a thorough record of evidence seen and reviewed related to the work history of locums, their qualifications and registration.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this as the practice had an extensive list of locum GPs that could be used and the practice booked locums up to eight months in advance to ensure that patients had consistency in seeing the same locums.

The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. An example seen was a carer's lead had been established to maintain a carers register at the practice and we saw information boards signposting carers to NHS support and helpline. The practice was able to monitor carers and patients and encouraged carers to attend for health checks.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (An automated external defibrillator (AED) is a lightweight, portable device that delivers an electric shock through the chest to the heart. The shock can stop an irregular rhythm and allow a normal rhythm to resume in a heart in sudden cardiac arrest). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator and they were within their expiry date.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned

Good

Are services safe?

sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in 2013.

The practice had carried out a fire risk assessment in 2012 and the fire policy was reviewed in February 2014 and included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. All fire equipment had been tested and serviced in May 2015. We saw laminated fire information cards were displayed in all the rooms.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

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

The GP told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

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

Discrimination was avoided when making care and treatment decisions. Interviews with the GP showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

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

The practice showed us two clinical audits that had been undertaken in the last two years. These were completed audits where the practice was able to demonstrate the changes resulting since the initial audit.

The practice had a system in place for completing clinical audit cycles. The practice showed us a clinical audit that had been completed recently. For example as part of the clinical commissioning improvement plan the practice had carried out a fast track urology audit from October 2013 to June 2014. There were seven referrals reviewed, the results showed that 100% followed two week wait guidelines and cancer was diagnosed in those referrals where it was suspected. Of those where no cancer was found one could have been avoided by treatment with an urgent catheterisation in the community.

The GP told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of antibiotic quality specifically relating to specific antibiotics. Following the audit, the GPs

Good

Are services effective?

(for example, treatment is effective)

carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 100% of the total QOF target in 2014, which was above the national average of 94.2%. Specific examples to demonstrate this included:

• Performance for diabetes related indicators was better than the national average.

• Performance for mental health related and hypertension QOF indicators were similar to the national average.

• The dementia diagnosis rate was comparable to the national average.

The practice made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff said they discussed and reflected on the outcomes being achieved and areas where this could be improved.

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as learning disabilities. Structured annual reviews were also undertaken for people with long term conditions, for example diabetes and heart failure. We were shown data that the practice was similar to expected to the national average of these that had been carried out in the last year.

The practice participated in local benchmarking run by the Dorset clinical commissioning group. This was a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example the urology audit was completed as part of the clinical commissioning plan.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending courses such as annual basic life support. Both GPs were up to date with their yearly continuing professional development requirements and either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the infection control lead nurse attended quarterly training which was then cascaded down to all the staff.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines. Those with extended roles, for example seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hour's reports, 111 reports and pathology results were all seen and dealt with by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and dealt with on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

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

Information sharing

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

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

Consent to care and treatment

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

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. For example, the practice kept records and showed us that 86% of care plans had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

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

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs

Good

Are services effective?

(for example, treatment is effective)

Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice's performance for the cervical screening programme was 87%, which was above the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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

• Flu vaccination rates for the over 65s were 74%, and at risk groups 54%. These were above the national averages.

• Childhood immunisation rates for the vaccinations given to under twos was recorded at 100% and five year olds at 100%. These were above Dorset clinical commissioning group and National averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

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

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was generally above average for its satisfaction scores on consultations with doctors and nurses. For example:

• 90% said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 89% and national average of 87%.

• 96% said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and national average of 92%.

Although, there was a less positive result:

• 79% said the GP gave them enough time compared to the CCG average of 88% and national average of 85%.

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received five completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with six patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, in the national patient survey 90% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 67%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the senior partner. The senior partner told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this has been discussed.

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

Care planning and involvement in decisions about care and treatment

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

• 88% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 84% and national average of 82%.

Good

Are services caring?

• 80% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 77% and national average of 74%.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Patient/carer support to cope emotionally with care and treatment

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

• 91% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 85% and national average of 82%.

However the following was less positive

• 77% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 79% and national average of 78%.

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

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

Staff told us that if families had suffered bereavement, their usual GP contacted them. This call was either followed by giving them advice on how to find a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). Such as supporting increased awareness of dementia in the local community. There had been enough interest to hold a 'Dementia Friends' event and with the increasing incidence of this condition, particularly amongst older people. The event aimed to increase the knowledge and learning ways that the practice and patients could identify and support people living with dementia.

Tackling inequity and promoting equality

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

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities.

There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

Access to the service

The practice was open from 8am to 6:30pm Monday to Fridays. The practice closed every lunchtime from 12.30 to 13.30 but the telephone was manned.

An evening surgery was held on Mondays from 6.30pm to 8.30pm. This was for pre-booked appointments only. During this period the practice telephone was answered by 111/out of hour's service.

When the practice was closed emergencies was covered by the South Western Ambulance Service NHS Foundation Trust out of hour's service.

Patients were seen by appointment during surgery hours and reception staff were available to answer calls from 8am onwards. Patients were asked to telephone after 9.30am to make a routine appointment or request a home visit, unless the matter was urgent.

Patients were able to speak with a GP, practice nurse or district nurse and this was usually without the need for a call back being made by the relevant health professional. If necessary the health professional was contacted via a pager or mobile phone to respond more quickly to the message. Time was made available in GPs morning surgeries to respond to requests for telephone consultations if they were unable to respond immediately to a request.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

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

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

• 87% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.

• 84% described their experience of making an appointment as good compared to the CCG average of 81% and national average of 73%.

• 82% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 67% and national average of 65%.

• 87% said they could get through easily to the practice by phone compared to the CCG average of 81% and national average of 71%.

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

Examples seen of how the practice responded to different population groups were:

• For older people and people with long-term conditions – home visits are available where needed and longer appointments when needed

• Families, children and young people - Appointments available outside of school hours for children and young people, suitable premises for children and young people and joint working with sexual health clinics

• People whose circumstances may make them vulnerable - Partnership working to understand the needs of the most vulnerable in the practice population, local health authority public health department, longer appointments for those that need them, flexible services and appointments, including for example, avoiding booking appointments at busy times for people who may find this stressful.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were 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 for example there were notices displayed, a summary leaflet available and information posted on the practice website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way. The practice displayed openness and transparency with dealing with the compliant. We tracked one complaint from an informal verbal complaint that was recorded by staff in a complaints book. This was actioned by the GP and coded. A formal letter of complaint was received and collated with the informal complaint. The complaint was then investigated by the GP and a timely letter sent with result which the patient was happy with.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Requires improvement

(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 vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy. These included offering a friendly, caring good quality service that was accessible to all patients. This was a small practice with a great personal knowledge of all its patients many of whom have been at the practice with the same two GPs for many years. The practice was trying to deal with the challenges of moving forward but at the same time providing a personal service tailored to the needs of the local population and continuing to be a viable business.

We spoke with seven members of staff and they were not sure they all knew and understood the vision and values and what their full responsibilities were in relation to these.

Governance arrangements

The senior GP partner was the registered manager for the practice. At the time of our visit the practice did not have a dedicated practice manager. The senior partner undertook the duties of the practice manager. In order to fulfil the business needs of the practice the senior partner employed locum GPs to see patients on a regular basis. There appeared to have been several changes in the roles of staff since the last practice manager left the practice. This had placed some stress on all the staff who told us that they had to deal themselves with day to day challenges that the previous practice manager would normally have dealt with. The senior partner had taken on these duties and staff considered that his time as a GP was precious and did not want to bother him with administration questions. An example given was when computer problems occurred; staff had to deal with arranging maintenance and repairs.

Staff also said they were concerned that the senior partner was trying to fulfil too many roles in the practice and this could impact on their ability to carry out all duties and tasks required.

There was a leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with seven members of staff and they were all clear about their own roles and responsibilities.

They all told us they felt valued, most of the time supported, but not always able to find who to go to in the practice with any concerns. For example the practice used a number of locums when the partners were on leave and on occasions, due to the working hours of the partners and leave periods, staff felt there was not always a person to speak with immediately in the practice who had the appropriate authority to act on their concerns. The staff did confirm that they were allowed to call the GPs mobiles if required.

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

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

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 10 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 10 policies and procedures we looked at had been reviewed annually and were up to date.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were generally approachable and when they were not busy listened to the staff, when they were present in the practice. All staff were involved in discussions about how to run the practice and how to develop the practice.

Are services well-led?

Requires improvement

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

We saw from minutes that team meetings were held every three months although meetings for reception staff had not taken place since November 2014. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident in doing so. Generally the staff said that they felt that the practice tried to support them. They said they felt respected and the practice had a good team spirit.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups although the majority were from the older age group. The PPG had carried out surveys and conduct business by email. The senior partner showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. An example of the practice responding to feedback was that the number of telephone appointments was increased and was now deemed to be at an appropriate level. The results and actions agreed from these surveys were available on the practice website. We spoke with one member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

The practice had also gathered feedback from staff generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. A discussion had taken place at a team meeting regarding an event where a patient felt that they had been spoken to without respect. The incident was treated as a useful reminder that all working at the practice must continue to treat everybody that they came into contact with fairness, respect, dignity and compassion.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance Regulation 17: Good Governance. How the regulation was not being met: The management responsibilities did not always ensure the quality and safety of the practice as there were no overarching governance arrangements. For example not all staff had relevant meetings to attend in order to feel supported and contribute to the vision and values of the practice. There was not a consistent programme of review for policies and procedures. Providers must ensure that their audit and governance systems remain effective. Regulation 17(2) (b). Health and Social Care Act 2008(Regulated Activities) Regulations 2014.