Lilliput Surgery

Quality Report

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

Summary of findings

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Summary of findings

Overall summary

Lilliput Surgery provides primary medical services for about 9,700 patients in the Parkstone area of Poole in Dorset. The address of the surgery was Elms Avenue, Poole, Dorset, BH14 8EE.

The practice provided a range of services for patients in all the population groups. The practice was registered with us for the following regulated activities: Diagnostic and screening procedures, Family planning practices, Maternity and midwifery practices, Surgical procedures and Treatment of disease, disorder or injury .

There were clinics for the management of chronic diseases such as asthma and diabetes. They also offered other medical practices including antenatal and postnatal care, minor surgery, childhood vaccinations and well-person check-ups.

The majority of patients we spoke with, or those who completed our comment cards or responded to the practice patient survey in 2013, were positive about the practice and staff.

There was evidence of collaborative working between the practice and the local clinical commissioning group (CCG). A GP partner was the chair of a group of practices within the CCG.

The group was involved in influencing and shaping local practices to meet local patients needs.

The practice anticipated and responded to patients needs to ensure they were met effectively.

Older patients were particularly well supported by the practice.

The practice had responded appropriately to safeguarding concerns and had clear and effective processes and procedures to keep vulnerable adults and children safe.

There were good governance system and management systems in place

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. The practice had clear safeguarding policies and procedures for the protection of vulnerable adults and children which were known to all the staff team. Patients were protected from the risk of infection because appropriate guidance had been followed. Patients received care and treatment in a clean, hygienic environment. The staff team learnt from incidents and complaints and made improvements to the practice.

Are services effective?

The practice was effective. Patients care and treatment was delivered in line with best practice and current legislation and guidance.

The practice ensured outcomes for patients were monitored to ensure patients received the care and treatment that best met their needs. Patients were supported in relation to health promotion and the prevention of ill health. There were effective staff training, recruitment and selecting processes in place.

The practice was supported by a virtual Patient Participation Group (PPG). This is a group of patients registered with the practice who assisted the practice to improve and develop their practices to meet the needs of patients at the practice. Feedback was provided electronically.

Clinical meetings and audits were used to assess GP and nursing staff performance.

Are services caring?

The practice was caring. Patients experienced care, treatment and support that met their needs and protected their rights. All of the patients spoken with or who responded to our comment cards were positive about the staff team. They described the team as caring, kind, efficient and thoughtful. We observed warm and compassionate interactions with patients from all members of the staff team.

Are services responsive to people's needs?

The practice was responsive to patients needs. The practice worked collaboratively with Dorset Clinical Commissioning Group (CCG) and local health organisations to identify the health needs of the local population and improve practices. The practice responded quickly to improvements suggested by the patient survey or via the PPG. There was a clear and effective complaints policy in place.

Summary of findings

Are services well-led?

The practice was well led. The GP partners and practice management encouraged ongoing training and development for both clinicians and staff. Staff and patients we spoke with were positive about the management of the practice. There were clear governance systems in place. They identified and managed risks and monitored the quality of the practice.

Summary of findings

The six population groups and what we found

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

Older people
Older patients were supported by the practice by good communication with the out of hours practice to ensure housebound patients had access to timely home visits. The practice worked closely with several local nursing homes to ensure patients received consistent care from GPs. Older patients were supported by the practice by good communication with the out of hours practice to ensure housebound patients had access to timely home visits. The practice worked closely with several local nursing homes to ensure patients received consistent care from GPs.

People with long-term conditions
Patients with long term conditions were supported to manage their health, care and treatment. They benefitted from effective information and guidance from the practice about the management of their conditions. The practice worked closely with other practices in the Clinical Commissioning Group (CCG) to further develop good practice. Patients spoke positively about having dedicated staff for the treatment of patients with diabetes.

Mothers, babies, children and young people
The practice had a variety of clinics to assist mothers, babies and young children. The close proximity of the health visitors and district nurse to the practice meant patients benefited from timely referrals. The practice had effective safeguarding vulnerable children policies which supported the needs of young people.

The working-age population and those recently retired
The opening times were 8.00 am – 6.00 pm. Patients told us this was useful to working patients who found it difficult to attend the practice during the day. The opening times were on the website and on display in reception.

People in vulnerable circumstances who may have poor access to primary care
Patients in vulnerable circumstances were supported by the practice as staff assessed and monitored their needs. There were support groups for carers and vulnerable patients at the practice and the practice ensured patients had information about local services and community groups.

Summary of findings

People experiencing poor mental health

Patients with mental health problems were supported by the practice. Staff worked closely with the Dorset Clinical Commissioning Group (CCG) and local mental health organisations to improve outcomes for patients with mental health conditions.

Summary of findings

What people who use the service say

We spoke with 13 patients during the inspection. This included 10 older patients, two patients of working age and one mother with two children. We also received seven comments cards from patients who had visited the practice in the previous two weeks. The majority were positive about the practice they had received.

All of the patients spoke positively about the staff team and described the practice as second to none. Patients told us they were involved in decisions about their care and treatment.

Some patients told us they found it difficult to see the same GP at each visit and difficult to park in the car park but acknowledged the changes the practice had made to improve both these areas.

We also looked at the results of the latest national GP survey that collected the views of patients who used the practice. 70% of patients rated the practice as good or very good. Feedback left by most patients on the national NHS Choices website also showed a high satisfaction rate with the practice.

Areas for improvement

Action the service COULD take to improve

Patients with a learning disability did not have information in a pictorial format. This meant they did not benefit from the same access to information as other patients.

Good practice

Our inspection team highlighted the following areas of good practice:

- Patients were very positive about the frequency and availability of home visits. These were either at patients request or as a result of information from the out of hours practice.
- There was effective liaison with the out of hours practice by a named GP from the practice each day. This ensured patients received consistent and effective follow up treatment.
- Patients were able to access useful advice and guidance from the practice website to assist in the self-management of longterm conditions and promote their health and wellbeing.

Lilliput Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP. The team included two CQC inspectors and a practice manager.

Background to Lilliput Surgery

Lilliput Surgery provided primary medical services to the Parkston area of Poole. Approximately 9,700 patients were registered with the practice. The address of Lilliput Surgery was Elms Avenue, Poole, and Dorset.

The practice provided a range of services for patients. These included clinics for the management of chronic diseases such as asthma and diabetes. They also offered patients antenatal and postnatal care, minor surgery, childhood vaccinations and well-person check-ups.

The practice occupied a purpose built building. A local pharmacy was situated at the front of the building. There were other teams, including health visitors and district nurses in the building and a counselling practice.

Patients were supported by a number of GPs, nurse practitioners, health care assistants, a practice manager and administration staff. The practice was a member of the Dorset Clinical Commissioning Group (CCG).

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

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

We carried out an announced visit on 2 June 2014 between 9am and 5pm.

Detailed findings

During our visit we spoke with a range of staff, including the senior partners of the practice, a salaried GP, the practice manager, nursing and administration staff.

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

Are services safe?

Summary of findings

The practice was safe. The practice had clear safeguarding policies and procedures for the protection of vulnerable adults and children which were known to all the staff team. Patients were protected from the risk of infection because appropriate guidance had been followed. Patients received care and treatment in a clean, hygienic environment. The staff team learnt from incidents and complaints and made improvements to the practice

Our findings

Safe patient care

The practice was registered with a central alerting system. Safety alerts like those about the recall of medicines were sent directly to the practice manager and then were cascaded to all staff.

Staff we spoke with were aware of the incident reporting process and understood how to respond to and report safety related incidents.

We saw that the manager monitored and analysed the levels of accidents, incidents and complaints to ensure patients were safe.

Learning from incidents

All incidents whether clinical or operational were recorded on an incident reporting log. Investigations took place by the partners of the practice and /or the practice manager. The practice manager ensured incidents were investigated promptly. Any identified learning or changes in practice were actioned to ensure the safety of patients.

Significant events were reviewed regularly at clinical governance meetings to analyse trends. There was a low reporting of incidents across the practice. GP partners told us some minor incidents or concerns were not recorded but larger risks were resolved quickly. For example, risks like the oxygen cylinder valve not being easily opened in an emergency was discussed and rectified immediately after the event took place. An action plan was devised to prevent a reoccurrence of the incident.

Safeguarding

Children and adults were protected from the risk of abuse as clear systems were in place to identify patients who may have been at risk.

We spoke with the GP safeguarding lead who was also a partner at the practice. They described how practice policies and procedures included the early identification of risk. They worked alongside other practices in the area. The safeguarding lead had links with the local authority safeguarding teams and a role in the Clinical Commissioning Group (CCG) about safeguarding.

The majority of staff had received an appropriate level of training for protecting vulnerable children and adults at their induction and then updates via e-learning. The practice ensured staff including administrative staff had

Are services safe?

their level one and two training in safeguarding adults and children. They also provided one training session for safeguarding in protected time for all the staff in the practice. All GPs had a minimum of level two children safeguarding training. Three GPs had completed level three training.

Staff members were well informed about identifying and preventing abuse. They were able to give examples where they had followed the safeguarding procedures to ensure the safety of vulnerable adults and children. All staff spoken with had a good understanding of the different types of abuse. They told us they would immediately speak with either the safeguarding lead or line manager, if they had any concerns about a patient if they thought they were at risk.

The practice safeguarding policies and procedures were available in the staff handbook which was easily accessible to all staff. In reception there was information for patients about safeguarding people from abuse. This included who they should contact in the event of identifying a concern or to report signs of abuse to. There were contact telephone numbers for children safeguarding referrals displayed in all treatment rooms.

There were additional safety checks in place for patients who used the practice. For example, the phlebotomist told us they confirmed patients date of birth before taking blood and checked this information against electronic records. They told us they only took blood from patients over the age of sixteen. Children's blood was taken by a practice nurse or GP to ensure their safe care.

Monitoring safety and responding to risk

Staff told us patients whose health was deteriorating whilst waiting in the reception area were seen quickly by the GPs. There were many risk assessments in place to ensure patient safety. These included risk assessments about the safe use of the building, equipment and fire safety.

Medicines management

Patients benefited from safe management of medicine practices in the practice. There were up to date medicines management policies which were known to all staff we spoke with at the practice.

Medicines were kept securely with appropriate staff access. Expiry dates on medicines were regularly checked and those out of date were appropriately disposed of. There were standard operating procedures (SOP) for using certain drugs and equipment to ensure their safe use.

Fridge temperature checks were undertaken on a daily basis to ensure they were stored at the correct temperatures. Each GP had a medicine and equipment bag ready to take on home visits for which they were each responsible. A GP told us their bags were regularly checked to ensure that the contents were intact and in date.

The infection control lead and practice nurse ensured emergency equipment including adrenalin and other medicines were all in order and in date. It was the role of a practice nurse to check each month and report to the practice manager.

Any medicine related issues were reported appropriately to external organisations and recorded as significant events in the practice. These were always discussed at monthly clinical meetings and actions taken.

There were no controlled drugs held in the practice. Controlled drugs are medicines which require extra checks and special storage arrangements because of their potential for misuse.

Cleanliness and infection control

Effective systems were in place to reduce the risk and spread of infection. The practice had a named infection control (IC) lead who had been in post for two months. This person demonstrated a sound knowledge of infection control policies and procedures. Infection control audits had been completed annually; the latest was completed in May 2014. This audit contained dates when the corrective action was completed. One audit identified the decision to replace the carpets in GP rooms with linoleum if they became damaged.

All staff completed basic infection control as part of induction. The practice manager and IC lead said they were organising external IC training for two staff to roll out to all staff later this year. This meant the practice ensured they met the requirements outlined in Department of Health's publication, 'The Code of Practice for health and adult social care on the prevention and control of infections and related guidance'. Hand washing guidance was available above all of the sinks in the treatment rooms and toilets.

Are services safe?

Soap dispensers were available in public areas like reception. There were soap and hand towels at every sink throughout the practice. Staff and patients used these dispensers frequently.

Personal protective equipment like gloves and aprons were available and used by the staff team. The curtains in the treatment rooms were disposable with dates of replacement clearly visible.

The cleaning contract of the building was managed and provided by an external contractor. We were told by the practice manager they reviewed the cleaning contract every six months and found them to be in line with the code of practice. We noted all areas of the practice were visibly clean and tidy which contributed towards a clean and hygienic environment for patients.

There was an environmental cleaning schedule for staff to follow and we saw a copy of this which had been signed each day. Cleaning products for use in different areas of the building were described in the schedule to ensure clinical and non-clinical areas were appropriately cleaned by staff.

We found all the treatment and consulting rooms were clean and hygienic with clutter free work surfaces. Furniture within the waiting room was well maintained. The seats were covered in a wipe clean fabric. The flooring in the waiting rooms was carpet and in the treatment rooms was linoleum.

All the patients we spoke with were positive about the standards of hygiene and cleanliness in the practice. They described the practice as clean and tidy.

Staffing and recruitment

Patients were cared for, and treated by, suitably qualified, skilled and experienced staff. There were effective recruitment and selection processes in place and appropriate checks were undertaken before staff began work.

We looked at the staff files for three recently recruited nurses and two most recently recruited GPs personal files. All the nursing files were well organised and included references, copies of appropriate identification, criminal records checks through the disclosure and barring practice (DBS). Interview notes, two references, Nursing and Midwifery Council registration status, training certificates, induction checklist and signed contract including confidentiality clause.

However the GP files were not as well organised and did not contain two references. The files did contain GMC status, education and training and membership of Wessex deanery scheme (this scheme ensures GPs are on NHS providers list and are licenced to practice).

People were cared for by staff who were supported to deliver care and treatment safely and to an appropriate standard. For example. The phlebotomist had to undertake 100 supervised appointments (after initial training by local NHS Trust) then they were assessed by a practice nurse before commencing their role to ensure they were competent to treat patients safely.

All non GP staff confirmed they had appraisals and we saw a checklist devised by the practice manager to confirm their completion. The appraisals did not contain measurable objectives for staff members. This meant staff would not be able to easily evidence their achievements. The appraisals were not consistently structured. For example, they did not all contain staff training and development needs. All GP appraisals were conducted by the Clinical Commissioning Group.

Dealing with Emergencies

All staff had training in basic life support. Staff had access to medicines, a mobile defibrillator, a nebuliser and oxygen. We saw information which recorded emergency equipment had been regularly checked and serviced as required

Potential risks to the practice were anticipated and planned for in advance. Plans were in place to deal with emergencies that might interrupt the smooth running of the practice. The practice had identified another local practice for potential use if they became unavailable for any reason. There was also an ice and snow plan in place for staff to follow to ensure the safety of patients.

Equipment

There was appropriate equipment, drugs and oxygen for use in a medical emergency. The automated defibrillator was seen to be working and well maintained. Oxygen was in place and regularly checked to ensure its safe use. It had been replaced last year after an incident where a previous bottle had been difficult to open. The event had been recorded as an incident and an action plan had been followed to ensure staff had easy access to the oxygen in case of an emergency.

Are services safe?

There was also a spillage cleaning kit with the other emergency equipment and the procedures for its use were known to staff.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. Patients care and treatment was delivered in line with best practice and current legislation and guidance.

The practice ensured outcomes for patients were monitored to ensure patients received the care and treatment that best met their needs. Patients were supported in relation to health promotion and the prevention of ill health. There were effective staff training, recruitment and selecting processes in place.

The practice was supported by a virtual Patient Participation Group (PPG). This is a group of patients registered with the practice who assisted the practice to improve and develop their practices to meet the needs of patients at the practice. Feedback was provided electronically.

Clinical meetings and audits were used to assess GP and nursing staff performance.

Our findings

Promoting best practice

People experienced care, treatment and support that met their needs. Care and treatment was delivered in line with recognised best practice standards and guidelines. The practice held monthly clinical meetings about relevant National Institute for Health and Care Excellence (NICE) guidelines. This ensured they kept up to date with new guidance, legislation and regulations. For example they followed NICE guidelines for the management of long term conditions like diabetes.

Management, monitoring and improving outcomes for people

The practice evidenced they provided good outcomes for patients by participating in nationally and locally recognised benchmarking programmes to measure themselves against other practices. For example they completed the Quality and Outcomes Framework (QOF) to demonstrate their achievements. They had full points on all assessed areas to show they were judged to be significantly better than many other practices. They noted they had a two percent decline in blood pressure control for older people and told us they were currently reviewing ways to address this decline.

Patients at the practice benefitted from two “pods” with machines where they could independently take their weight, BMI blood pressure readings without the need to make an appointment. Patients spoke positively about this system calling it enabling. They told us it assisted and encouraged them to be proactive in the monitoring of their weight and blood pressure. For example four patients told us the results had been an early indicator of some health issues for them.

Staffing

There were sufficient staff on duty to provide safe and effective care and treatment for patients. The staff team included ten receptionist, two administrative staff, three secretaries, four partners, two salaried GPs, two registrars and three practice nurses.

The practice manager and the partners reviewed practice activity to forecast staffing needs for periods like bank holidays and Christmas. The rotas were adjusted to ensure there were sufficient staff on duty to provide an effective care and treatment for patients.

Are services effective?

(for example, treatment is effective)

We looked at the induction and training for staff. We found there was an induction for new staff members to the practice. This covered mandatory and essential training, including safeguarding, basic life support, infection prevention and control, and patient confidentiality.

We spoke with three reception staff who all completed an induction at the start of their employment with the practice. This was in line with the practice induction procedure. They each had a probationary period, with regular reviews of competence prior to being offered a substantive post. They all described induction as very thorough and stated it enabled them to start working at the practice knowledgably and with confidence.

All staff training records were held by the finance administrator and then the practice manager reminded staff to complete outstanding training. There was a rolling programme of mandatory and essential training, including safeguarding, basic life support, infection prevention and control and patient confidentiality. Training records confirmed mandatory training had been completed by all staff.

Working with other services

Patients health, safety and welfare was protected when more than one provider was involved in their care and treatment, or when they moved between different practices. This was because the provider worked in co-operation with others.

One of the partners was actively involved in the Dorset Clinical Commissioning Group (CCG) as they were the chair of a group of practices within the CCG. The group looked at joint working arrangements across the local area for better outcomes for patients. Information from the CCG was shared and discussed at these meetings amongst the participating practices. For example, one recent meeting covered the latest guidance and local resources about the care and treatment of patients undergoing palliative care.

Staff proactively engaged with other health and social care providers to coordinate care and meet patient needs. Patients moving into the area from other practices were immediately offered an appointment. If they declined then the practice waited until they received their treatment records from the other practice then they were invited in for an appointment. Follow up work included communication between the two practices if there were any concerns about the patient.

There were joint working arrangements and primary health care meetings with other health professionals like district nurses, health visitors to work collectively in support of patient care and treatment.

Housebound patients were supported by the practice as they maintained good communication links with the out of hours practices. A designated GP followed up any issues which arose out of hours and arranged appropriate home visits. Effective communication between the practice, health visitors and community nursing teams was assisted by the close proximity of the local district nurse team in the same building. A GP told us this assisted with timely patient referrals.

Health, promotion and prevention

Patients had access to information about health promotion and wellbeing to assist their care and treatment. There were health promotion leaflets in the waiting room which sign posted patients to local support groups. GPs and nursing staff gave patients information leaflets regarding newly diagnosed long term conditions. The practice website also contained links to other webpages which provided advice and support for patients health and well-being. However, patients with a learning disability did not have information in a pictorial format. This meant they did not benefit from the same access to information as other patients.

Patients benefitted from having a variety of health professionals onsite. There were counsellors, district nurses, health visitors and midwifes available for clinics and patient referrals.

There were clinics for the management of chronic diseases such as asthma and diabetes. They also offered other medical services including antenatal and postnatal care, minor surgery, childhood vaccinations and well-person check-ups. There were some screening programmes in place. For example, there was a programme for early detection of vascular conditions.

There was a virtual Patient Participation Group (PPG) with thirty to forty members run by one of the partners of the practice. They used an on line survey system to get feedback about the practice. For example patients were concerned about the limited space in the car park so a partner contacted the landlord and they were able to add

Are services effective?

(for example, treatment is effective)

two car spaces. The partner told us they were unlikely to develop the PPG into a real group due to the limited interest. They told us they got better take up of views using the virtual PPG than from paper surveys to patients.

There were two information screens in the practice with information about promoting patients health. It was regularly updated by one of the partners so patients had easy access to new information. For example, patients were informed about the introduction of a new local telephone number so patients did not have to use the more expensive one.

Are services caring?

Summary of findings

The practice was caring. Patients experienced care, treatment and support that met their needs and protected their rights. All of the patients spoken with or who responded to our comment cards were positive about the staff team. They described the team as caring, kind, efficient and thoughtful. We observed warm and compassionate interactions with patients from all members of the staff team.

Our findings

Respect, dignity, compassion and empathy

Before the inspection took place we asked patients who used the practice to complete comment cards regarding the care and treatment they had received. We received seven completed cards. All of the comments were positive and demonstrated that people were extremely satisfied with the care they had received.

We observed four reception staff members interactions with patients. They were seen to be warm, courteous and kind. They were all aware of the need to keep patients information confidential.

Patients could be confident their information would be kept confidential and there were opportunities for patients to talk to reception staff, the practice manager and GPs privately. GPs and staff had received training on information governance and patient confidentiality in a 'protected' learning session in June 2014. Staff were knowledgeable about the confidentiality policy and demonstrated they knew how to use it on a daily basis.

The practice had a large area in reception with signs to advise patients to wait out of earshot of those speaking to the receptionist. There was also an electronic book in facility to assist patients.

There was information about records and information displayed in the waiting room and on the practice website. This explained what information the practice held about patients, how the information was used, and how patients could access their records.

Chaperones were arranged through the reception manager in response to request from patients and GPs. All staff were checked via the Disclosure and Barring Practice (DBS) regardless of their role before chaperoning patients. Patients spoke positively about the practice.

Involvement in decisions and consent

The majority of patients told us they felt they had been listened to and their treatment and care met their needs. Patients spoke of the friendliness and helpfulness of staff and GPs. They described the practice as second to none.

Are services caring?

There was a patient centred approach to care and treatment from all staff. Patients with long term conditions were well supported to manage their health, care and treatment. Detailed care planning was in place for patients with long term conditions such as diabetes and asthma.

All patients we spoke with told us they felt involved in their treatment. They confirmed they made decisions with the clinical staff. Patients confirmed they gave their consent for any treatment they received.

Patients received advice and information to help them manage their conditions. This included advice about self-management and treatment options.

All of the staff we spoke with were aware of the importance of supporting patients with impaired mental capacity in regards to decision making.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patient needs. The practice worked collaboratively with Dorset Clinical Commissioning Group (CCG) and local health organisations to identify the health needs of the local population and improve practices. The practice responded quickly to improvements suggested by the patient survey or via the Patient Participation Group (PPG). There was a clear and effective complaints policy in place

Our findings

Responding to and meeting people's needs

The practice had low admission rates and referrals to the accident and emergency department at the local hospital. The GP partners told us this was due to the large number of patients treated in their own home. They told us patients had requested this service and the practice had quickly responded. Older people were able to phone for prescriptions and the practice arranged for the pharmacist in the same building to deliver them to the patients home.

The building was accessible for all patients using a wheel chair or with a child using a pram as there was a ramp leading to the reception area and lifts to all clinical areas. The doors were also wide enough to accommodate wheelchair users. The area in front of reception was spacious to facilitate several patients waiting or using the monitoring machines.

The practice proactively monitored the prevalence of long term conditions within their local population. They kept up to date about and reviewed the treatment pathways. The practice developed a checklist and template for end of life and LTC to ensure all tasks were completed.

The practice also met the needs the needs of mothers and young children. For example, in response to increased numbers of mothers and young people in the area the health visitors had established close links with the Community Children's centre to ensure good communication and care.

The leadership of the practice continuously assessed and monitored the practice population needs, including the needs of people in vulnerable circumstances. They held 'vulnerable patient meetings' and invited other professionals like local authority social workers to discuss both individual and community needs.

Twelve months ago the practice introduced two patient information screens to provide information like flu reminders and any surveys taking place. Discussions with staff, patients and information on the practice website confirmed patients were positive about this method of communication.

The practice had access to a language line for patients for whom English was not their first language but not had to use it yet. One patient who was deaf required an interpreter

Are services responsive to people's needs?

(for example, to feedback?)

which was arranged by the practice. There was no hearing systems in place to assist patients with limited hearing. The practice manager told us this has been considered but was not felt to be a priority. The information for patients was not accessible to all patients as it was not in formats like pictures, large print or other languages.

Access to the service

Each day there was a designated GP who reviewed the out of hours notes from the previous night and then arranged home visits. Each day two hours were allocated to these home visits. A GP told us home visits were often used by older members of the community who may have limited mobility.

The opening times were 8.00 am – 6.00 pm with an extension until 7.40 pm each Monday for booked appointments. Patients told us this was useful to working patients who found it difficult to attend the practice during the day. The opening times were on the website and on display in reception.

Patients who needed to see a GP urgently were offered a same day appointment or a second day appointment if they wished to see their own GP. As a result patients were more likely to speak with a GP who knew them.

On the practice's website they identified four items which arose from their PPG discussions and surveys. These included the patients desire to see a particular GP, a review of the telephone answering system with access to GP appointments, use of the patient information screen and the limitations of the small car park.

As a result, the practice redesigned the appointments system to make it more accessible for patients. All calls from patients were triaged to ascertain the level of urgency. All urgent patient requests or patient requests for a same day appointment were then forwarded to the duty GP. This GP called back each patient and assessed if an urgent appointment was needed.

The practice advertised the changes to the appointment system and invited comments via the information screen in reception. Comments seen from the PPG were positive. Nine of the 13 patients we spoke with stated they had access to the same GP. Four patients stated they still experienced difficulty seeing the same GP. 40% of patient who responded to the practice survey stated they were happy with the new system and fifteen percent stated they were not.

This showed us the majority of patients were happy with the practice they received but there was still room for some improvement. The practice manager told us the changes to the appointment system had improved consistency for patients but they would continue to monitor and review their systems to ensure they always listened to patients requests.

The practice also responded to patients concerns in the surveys about limited parking and introduced some additional parking spaces. Patients told us they still found the parking in the small car park difficult. There was a direct telephone line to a taxi practice in reception and a copy of the local bus route on the notice board to assist patients without access to a car.

The practice had blood pressure and weight monitoring machines for patient use in both waiting areas. The ground floor one was linked into patient records so their blood pressure could be recorded and uploaded without need for them to make an appointment. If there were concerns the patient was contacted by the practice to make an appointment.

To assist patients on a limited income, like a pension, the practice changed its telephone number to a less expensive local number.

The time waited by patients to see a GP or nurse at the practice was in line with the national average.

Concerns and complaints

There was an effective complaints system available. Comments and complaints patients made were responded to appropriately.

The practice had a complaints policy and procedure. This was not displayed in the waiting area, but the reception manager agreed to action this quickly after the inspection. Patients told us they knew how to make a complaint and they would feel comfortable to do if the need arose. There was a comments box in reception. The practice manager told us they opened the box every month and replied to any comments.

Peoples complaints were fully investigated and resolved, where possible, to their satisfaction. A complaints folder was kept by practice manager. Alongside each complaint there was an acknowledgement letter, details of the

Are services responsive to people's needs?

(for example, to feedback?)

investigation and a copy of the final reply to the patient. All clinical complaints were investigated by a GP partner and administrative ones by the practice manager. This was in line with the current practice complaints policy.

Staff we spoke with were aware of the complaints process and told us how they would support a patient wishing to make a comment or complaint. The reception staff told us if patients wished to complain they would refer them to the practice manager, or take contact details and arrange for the practice manager to ring the patient back. The practice survey indicated a high level of satisfaction with the practice, resulting in very few complaints being made.

Every three months the practice scheduled 'Learning from complaints' as part of the regular weekly meeting, where learning points and actions were discussed. This meant the practice took account of patients complaints and comments to improve the practice. For example they approached the landlords of the property to increase parking spaces following patients complaints.

Are services well-led?

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

Summary of findings

The practice was well led. The GP partners and practice management encouraged ongoing training and development for both clinicians and staff. Staff and patients we spoke with were positive about the management of the practice. There were clear governance systems in place. They identified and managed risks and monitored the quality of the practice.

Our findings

Leadership and culture

The practice did not have a written vision and strategy. However, when asked, GPs broadly described the same vision. The vision included forward thinking, innovative practice and good quality care with good outcomes for people.

All of the staff we spoke with were able to describe values that were consistent with the overall ethos of the practice. The leadership and culture within the practice reflected the vision and values described to us by the staff team. For example staff told us there was an emphasis on innovation and positive outcomes for patients.

We spoke to two GPs who were clear about the practice leadership priorities and goals. For example one of the unique elements of the practice was its emphasis on training GPs. There was a dedicated room for learning and protected time for training. Currently the practice was aware one partner was going to retire so a programme was in place for senior GPs to take on additional senior roles. Clinical staff at all levels told us they felt supported to deliver high quality care.

The senior partners at the practice encouraged a culture of openness and transparency within the staff team. There was an incentive and reward scheme in place for all staff where bonuses were available for Quality Outcome Framework (QOF) achievements. There were team days and social events in place to assist team working. Staff described an open culture where they felt supported. They described a family type atmosphere where conflict was resolved. For example, there were some tensions between the morning and afternoon staff team. The teams met and discussed these matters and they were resolved to both teams' satisfaction.

Governance arrangements

The governance arrangements ensured responsibilities in the practice were clear to all staff. Quality and performance were monitored through practice meetings for all staff, clinical meetings and risk management meetings. The staff meetings included information about the smooth running of the practice and training opportunities for staff. The clinical meetings included discussions about best practice and new guidance. At the risks management meetings risks were identified and managed to ensure patient safety.

Are services well-led?

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

There was a clear system for lessons learnt to ensure safer practice. For example the practice highlighted some concerns about the filing system used for patient information and the systems were reviewed and improved by the staff team.

Systems to monitor and improve quality and improvement

The practice strived to continuously learn and improve, The partners held weekly meetings which addressed business learning, risk and strategy. There were electronic minutes which clearly stated current issues, future plans and outcomes with review dates where appropriate. For example, one current issue was about GP capacity concerns in the practice and how locum cover was arranged. All learning from any incidents was regularly addressed at these meetings. The partners used a system of peer review to audit their practice.

Patient experience and involvement

We looked at the results of the last national survey that collected the views of patients who used the practice. Patients were positive about the service they received. In the survey, 70% of patients rated the practice as good or very good and 64% of patients stated they could easily make an appointment with a GP. Patients who responded to the survey spoke of an open door culture in the practice that was second to none. There was strong collaboration with the patient participation group (PPG) to improve services for patients.

Staff engagement and involvement

All staff stated they felt confident to whistleblow (inform senior staff) if poor or bad practice was identified. They felt confident any concerns they raised would be resolved by the leadership team. We saw evidence of this within the meeting minutes and significant event analysis.

Learning and improvement

The practice was a teaching practice so there was an effective system for continued professional development and training available for clinical staff. Trainee GPs spoke positively about the training opportunities to develop their skills.

The GP partners and practice management encouraged ongoing training and development for all staff. Staff we spoke with told us the practice used protected learning time and staff meetings to develop their knowledge and skills. They spoke positively about the learning opportunities within the practice.

Identification and management of risk

The senior GP partner and practice manager were responsible for the governance, risk management and safeguarding lead roles within the practice. They held weekly meetings which addressed the identification and management of risks. For example the strategies in place to protect patients if the practice closed in the event of fire. Staff told us how data, audits and benchmarking information had been used to make improvements to standards of care and minimise any risks to patients.

Older people

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

Summary of findings

Older patients were well supported by the practice as there was good communication with the out of hours practice to ensure housebound patients had access to timely home visits. The practice worked closely with several local nursing homes to ensure patients received consistent care from GPs.

Our findings

Caring

There were support meetings for patients identified as carers for advice and guidance about financial matters, local resources and for ongoing support to assist them to care for their relatives.

There was information on the practices website about seasonal flu vaccinations and healthy lifestyles.

Effective

All patients over the age of 75 years had a named GP. The practice had links with several local nursing Homes. They provided a consistent practice as named GPs attended each nursing home.

Responsive

Some patients had a limited income like a pension and expressed concerns about the cost of practice phone number. In response the practice changed its telephone number to a local number to be more cost effective for patients on a low income.

Each day there was a designated GP who reviewed the out of hours notes from the previous night and then arranged home visits. Each day two hours were allocated to these home visits. A GP told us these visits were often used by older members of the community.

Well-led

The practice was working collaborative with other practices to draw together a pathway to reduce the number of admissions of older people to hospitals.

People with long term conditions

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

Summary of findings

Patients with long term conditions were well supported to manage their health, care and treatment. They benefitted from effective information and guidance from the practice about the management of their conditions. The practice worked closely with other practices in the Clinical Commissioning Group (CCG) to further develop good practice. Patients spoke positively about having dedicated staff for the treatment of patients with diabetes.

Our findings

Caring

Care plans for patients with long term conditions (LTC) were developed with patients to both promote independence and assist them manage their condition.

Patients benefited from yearly reviews to ensure conditions like diabetes were monitored and managed in line with patients choices in their care plans.

Effective

The practice held weekly clinics for patients with longterm conditions like diabetes and asthma. Patients with chronic obstructive pulmonary disease (COPD) had separate clinics run by nurses and GPs**.** The practices website contained information about LTC like asthma, COPD, diabetes and cancer.

The web site contained videos about longterm conditions and guidance about their management. For example there was a video on the diabetes site about how patients could take a blood test. On the COPD site there was a guide about the symptoms, diagnosis, treatment and risks of COPD. There was also information and guidance on living with the condition and links to other organisations for further assistance and advice.

There was a practice nurse who was a specialist in the treatment of diabetes. On the month of each patients birthday patients were sent information like current guidance and details of upcoming events.

Responsive

Patients with long term conditions received timely appointments. One patient told us they had an exacerbation of their asthma and they were offered an appointment the same day within ten minutes time of their having called the practice.

People with long term conditions

Well-led

The practice proactively monitored the prevalence of long term conditions within their local population. They kept up to date about and reviewed the treatment pathways. The practice developed a checklist and template for end of life and LTC to ensure all tasks were completed.

Mothers, babies, children and young people

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

Summary of findings

The practice had a variety of clinics to assist mothers, babies and young children. The close proximity of the health visitors and district nurses to the practice meant patients benefited from timely referrals. The practice had effective safeguarding vulnerable children policies which supported the needs of young people.

Our findings

Safe

Children and adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. Clear systems were in place to identify patients who may be at risk. The staff received sufficient training to enable them to identify and assist children who were at risk.

The practice was aware of any children who did not attend appointments at hospitals and they were offered timely appointments to ensure their safety.

There were additional safety checks in place for patients who used the practice. For example, the phlebotomist told us they confirmed patients date of birth before taking blood and checked this information against electronic records. They told us they only took blood from patients over the age of sixteen. Children's blood was taken by the practice nurse or a GP to ensure their safe care.

Caring

Patients who required additional support could be assisted by trained chaperones and request longer consultations with their GP.

Effective

The practice had a clear process to ensure the close monitoring of mothers, children and young people and families living in disadvantaged circumstances.

There was a health visitor available for easy referral in the building. The GPs in the practice held monthly meetings with the health visitors to discuss patients care and ensure a consistent approach to patients treatment and care.

There was a pregnancy planner on the website to assist pregnant women. The site included information about every stage of babies' development, feeding the baby and parents' legal rights and benefits

Mothers, babies, children and young people

Responsive

Parents and carers could access same day appointments for children and young people.

In response to increased numbers of mothers and young people in the area the health visitors had established close links with the Community Children's centre to ensure good communication and care.

The practice worked closely with other organisations to try and improve the health and wellbeing of the younger population. Patients were referred to sexual health programmes and given advice and information about community groups where they could access confidential consultations with trained staff.

Well-led

The leadership team ensured children followed an immunisation programme to ensure their safety. Written advice from the practice was sent to parents when routine immunisations were due. The practices had a variety of clinics to assist mothers, babies and young children. These included childhood immunisation clinics, midwife antenatal clinics**,** well baby clinics and child health surveillance.

Working age people (and those recently retired)

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

Summary of findings

The opening times were 8.00 am – 6.00 pm. Patients told us this was useful to working patients who found it difficult to attend the practice during the day. The opening times were on the website and on display in reception.

Our findings

Caring

Information about how to access sickness certificates was available on the practices websites to inform working age patients how to inform their employer of their sickness absence from work.

Effective

Patients were advised of the changes to the NHS regulations which promotes choice of practice so working patients could choose a practice closer to their place of work.

Responsive

The opening times were 8.00 am – 6.00 pm with an extension until 7.40 pm each Monday for booked appointments. Patients told us this was useful to working patients who found it difficult to attend the practice during the day. The opening times were on the website and on display in reception.

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

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

Summary of findings

Patients in vulnerable circumstances were well supported by the practice as staff assessed and monitored their needs. There were support groups for carers and vulnerable patients at the practice and the practice ensured patients had information about local services and community groups.

Our findings

Safe

Staff received training in safeguarding vulnerable people. There were sufficient systems in place to protect vulnerable adults.

The practice could arrange for prescriptions for vulnerable patients to be delivered to their home address by the pharmacy practice.

There were robust safeguarding policies and procedures for protecting vulnerable adults and children from abuse. The safeguarding lead had links with local authority safeguarding team and Clinical Commissioning Group lead so information could be easily shared.

Caring

Carers of patients from the practice were offered support packs. These included information about additional support they could access from the practice or within the community.

Practice staff worked with an advisor from a local carer centre. The advisor regularly visited the practice to provide more specific patient support and advice.

Effective

Patients with a learning disability did not have pictorial communication methods. This meant they did not benefit from the same access to information as other patients.

Patients in vulnerable circumstances could have longer consultations with health professionals and access to a chaperone.

Responsive

There was a local translation practice for patients for whom English was not their first language.

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

Patients had the opportunity to request longer appointments if they had communication concerns to assist their care and treatment.

House bound patients received support from the practice. The nursing team undertook annual reviews for patients with long term conditions in patients own homes.

Well-led

The leadership of the practice continuously assessed and monitored the practice population needs, including the needs of people in vulnerable circumstances. They held 'vulnerable patient meetings' and invited other professionals like local authority social workers to discuss both individual and community needs.

People experiencing poor mental health

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

Summary of findings

Patients with mental health problems were well supported by the practice. They worked closely with Dorset Clinical Commissioning Group (CCG) and local mental health organisations to improve outcomes for patients with mental health conditions.

Our findings

Effective

The practice had developed strong links with local mental health providers. They actively promoted practices such as a memory café where people with people with memory loss could meet for support. They were also looking at having a building in the garden to hold coffee mornings for people with mental health concerns, older or vulnerable patients.

There was a designated GP for home visits for patients with mental health concerns for continuity. The practice regularly reviewed the number of home visits for patients with mental health concerns. If the number of home visits was significant this triggered additional support like a referral to mental health provider.

Responsive

The practice held 'vulnerable patients' meetings with social workers and community mental health teams to promote integrated working and improve outcomes for people with mental health conditions.