Westbourne Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Westbourne Medical Centre on 6 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing effective, well-led, safe, 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).

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.
- Information about services and how to complain was available and easy to understand.
- 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.
- There was a clear leadership structure and staff felt supported by the management team.
- The practice proactively sought feedback from staff and patients, which it acted on.
- The practice had, where appropriate, given homeless patients a copy of their summary care record which they could share with any other GP they visited whilst travelling.

Summary of findings

However there were areas of practice where the provider needs to make improvements

Importantly the provider should:

- Ensure staff have completed training in the Mental Capacity Act 2005.
- Ensure that details of the practice's chaperone policy are prominently displayed.
- Take due care and attention to not sharing information inappropriately. There should be a risk assessment in place in relation to the access to patient records.
- Review the risk assessment to determine which staff require a Disclosure and Barring Service check (DBS) in line with up to date guidance, which requires all clinical staff (including healthcare assistants) to have a DBS check.

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 well managed. There were enough staff to keep patients safe. However some job roles had not been identified as needing a criminal records check such as for a health care assistant, where the role holder had been employed for a long time.

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.

However we had concerns that the practice's clinical record system could be accessed in the community pharmacy which shared the practice premises. Although there were advantages for patients in relation to safe prescribing not all patients not been made aware that access was possible from within the pharmacy.

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

Summary of findings

NHS England Area Team and the Dorset 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 with the duty team.

The practice had good facilities and was well equipped to treat patients and meet their 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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by the management team and GPs. The practice had a number of policies and procedures to govern activity and had a structured programme of meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active and held their own meeting as well as meeting with the practice at regular intervals. Staff had received inductions, regular performance reviews and attended staff meetings.

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 avoiding hospital admissions. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Twenty eight per cent of the practice population were over the age of 65 years of age. The practice was developing an 'over 75s' project which enabled improved care for patients in the community, encouraging independent living using tools such as self-management plans and engagement in local schemes and groups. The practice had recruited a community matron and health care assistant who would be dedicated to case management of the patients in this scheme.

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. Practice nurses and the healthcare assistant held specialist clinics for the management of patients with diabetes or lung disease. The pharmacist, from the co-located pharmacy was trained in spirometry and held clinics in the practice for the management of patients with asthma.

Families, children and young people

Good

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

Summary of findings

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.

There was a system to highlight vulnerable patients on the practice's electronic records. This included a system of cross referencing information onto children's records any history of domestic violence, drug or alcohol abuse of family members. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs of 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 had a record of those patients living in vulnerable circumstances including homeless people and those with a learning disability. The practice carried out annual health checks for people with a learning disability and offered longer appointments for these patients.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It told vulnerable patients how to access various support groups and voluntary organisations. The practice had, where appropriate, given homeless patients a copy of their summary care record which they could share with any other GP they visited whilst travelling. 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). Approximately 88% of people experiencing poor mental health had

Summary of findings

an agreed care plan documented in their record in the preceding 12 months. 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 cared for mothers in a nearby residential home for those who suffered poor mental health and had recently delivered a baby.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with dementia.

Summary of findings

What people who use the service say

We spoke with 15 patients on the day of our inspection. We did not receive any comments from patients on the comment cards which had been available to patients in the two weeks leading up to our inspection.

We spoke with patients from a number of population groups. These included families and children, people of working age, people with long term conditions and people aged over 75 years of age.

Patients were very complimentary about the practice staff who they said were helpful, friendly and respectful. There were mixed comments about the availability of appointments. However most of the negative comments were related to waiting times to see the patient's preferred GP. All patients we spoke with acknowledged the practice was able to provide urgent appointments the same day and routine appointments promptly. Five of the patients we spoke with had called that morning and had been given an appointment. Patients commented positively on the way GPs and nurses listened to them and the way they explained their diagnosis. They did not feel rushed during their consultation.

One of the patients we spoke with was eager to complement their GP for their caring manner. The patient praised what they considered was above the call of duty in the GPs responsiveness to the needs of one of their family, which included telephoning and visiting without being requested to, in order to check on their patient.

The last patient survey was published by the practice in March 2014. The results from this survey showed that 77% of patients found that the availability of appointments was either, good, very good or excellent. The most recent NHS England GP survey results published in January 2015 showed that 94% of those that responded found that their appointment was either fairly convenient or very convenient. Results from the GP survey published in January 2015 showed that 92% of those patients surveyed felt that their overall experience of the practice was good.

The practice collected feedback from patients in the friends and family test. In March 2015, 38 patients left responses which showed that 73% were likely to recommend the practice, 10% were unlikely and 17% did not answer or gave a neutral response.

Areas for improvement

Action the service SHOULD take to improve

- Ensure staff have completed training in the Mental Capacity Act 2005.
- Ensure that details of the practice's chaperone policy are prominently displayed.
- Take due care and attention to not sharing information inappropriately. There should be a risk assessment in place in relation to the access to patient records.
- Review the risk assessment to determine which staff require a Disclosure and Barring Service (DBS) check in line with up to date guidance, which requires all clinical staff (including healthcare assistants) to have a DBS check.

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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 a second CQC inspector, a specialist advisor in practice nursing and a specialist advisor in practice management.

Background to Westbourne Medical Centre

Westbourne Medical Centre is situated in Milburn Road, Westbourne, Bournemouth BH4 9HJ a residential area of west Bournemouth. Westbourne Medical Centre is part of the Dorset Clinical Commissioning Group. The practice operates from a building which is owned by the practice's GP partners. The practice building has 18 consulting rooms and five treatment rooms. A number of other rooms are used by visiting healthcare professionals. There is also a private healthcare company on the premises and a community pharmacy.

The practice has six male and two female GP partners equivalent to six whole time GPs. The clinical team also includes two salaried GPs a GP registrar, two nurse practitioners, a pharmacist prescriber, three practice nurses and a health care assistant. The practice is further supported by a practice manager and management team, reception and administration staff. The practice provides a range of primary medical services to approximately 16,400 patients and has a personal medical services (PMS) contract with NHS England. The PMS contract is a locally agreed alternative to the standard contract for delivering general medical services. This contract is used when services are agreed locally with a practice which may include additional services beyond the standard contract for delivering primary care services to local communities.

The practice is open each Monday from 8am until 8.30pm and from 8am to 6.30pm Tuesday to Friday and is closed between 12 and 2pm on Fridays during which time urgent calls are directed to the practice's urgent telephone line.

The Care Quality Commission draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality and Outcomes Framework, the National Patient Survey and data from Public Health England. This data showed the practice provides care and treatment to a higher than average number of patients who are over the age of 65 compared with the average for England and a larger than average number of patients aged between 25 and 35 years of age. This includes care and treatment to patients who live in one of the 31 care homes in the locality.

The GPs at this practice have opted out of providing out of hours services to their patients. When the practice is closed out of hours care and treatment is provided by the South West Ambulance Trust. Patients can access this service through the NHS 111 telephone number.

This practice was inspected in June 2014 as part of our new inspection programme to test our approach going forward. At that inspection we found that:

- The practice did not have suitable arrangements and procedures in place to fully protect patients from the risks of infection.
- The practice did not have suitable arrangements in place to ensure that care and treatment was provided to patients of all ages and diversities.

- The practice did not have suitable arrangements in place for obtaining and acting in accordance with the consent of service users.
- The practice did not have suitable arrangements in place to ensure all staff employed were appropriately trained and supervised to perform their duties.

At this inspection we found that these concerns had been addressed and all requirements met.

Why we carried out this inspection

We inspected this service as part of our comprehensive inspection programme. We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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 Westbourne Medical Centre we reviewed a range of information we hold. We also received information from local organisations such as NHS England, Healthwatch and the Dorset Clinical Commissioning Group. We carried out an announced inspection visit on 6 May 2015. During our inspection we spoke with patients and a range of staff, including five of the GP partners, a practice nurse and a nurse practitioner, the practice manager and members of the management team and reception and administration staff. We asked the practice to send us information about themselves, including their statement of purpose, how they dealt with and learnt from significant events, the roles of the staff and any examples of completed clinical audit cycles which had been used to assess performance and improve patient outcomes.

We looked at the outcomes from investigations into significant events and audits to determine how the practice monitored and improved its performance. We checked to see if complaints were acted on and responded to. We looked at the premises to check the practice was a safe and accessible environment. We looked at documentation available such as monitoring tools and policies and procedures for training, recruitment, maintenance and cleaning of the premises.

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to patient's needs?

• Is it well-led?

We also looked at how well services are provided for specific groups of patients 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 a buddy system had been put in place to ensure all correspondence was reviewed on the day it was received. This was following the review of a significant event where a hospital letter had not been reviewed for three days because a GP had been on holiday.

We reviewed safety records, incident reports and minutes of meetings where these were discussed. 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. We reviewed records of 37 significant events that had occurred during the last 12 months and saw this system was followed appropriately. 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 and felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We saw evidence of action taken as a result and that the learning had been shared. For example following a patient collapse in the practice the whole practice had discussed the incident to see if there was any learning that could be identified. There was an agreement that staff managed the situation well and staff contributed ideas to make improvements should the same situation arise. Such as the purchase of a suction device (to clear a patient's airway) which may be necessary in a similar situation and the purchase of screens to maintain the patients dignity. They also requested that simulated patient collapse formed part of future emergency training.

National patient safety alerts were disseminated to practice staff by the practice manager. Staff told us alerts were discussed at clinical meetings and GP and nurse 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 dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. GPs and nurses had either level two or three training in the subject and the leads for safeguarding had attained level three. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included a system of cross referencing information onto children's records any history of domestic violence, drug or alcohol abuse of family members. Information was shared with other relevant organisations including health visitors and the local authority.

There was a chaperone policy; however this was not visible on the waiting room noticeboard. Details of the chaperone policy were available to patients on the practice website. (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. Some reception staff acted as a chaperone if nursing staff

were not available, these staff had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

All non clinical staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks but some job roles had been identified as not needing a DBS check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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.

We saw records of clinical meetings that noted the proposed audits for the Clinical Commissioning Improvement Plan. For example, patterns of antibiotic prescribing, the use of high dosage corticosteroids in asthma and medication reviews of patients over 65 years of age with 10 or more repeat prescriptions.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health care assistant had received appropriate training to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

.The Westbourne Medical Centre has a community pharmacy business co-located at the same premises, co-owned by some of the practice partners, which is a separate legal entity. The practice's electronic record system extended into the area of the building used by the pharmacy, The pharmacist from the co-located community pharmacy was a contracted member of the practice team and provided clinical services, including medicines reviews and clinics for chronic disease management, for patients at the practice. The pharmacist employed in the co-located community pharmacy had direct access to patients' medical records for this purpose. However we found the practice had not ensured that all patients were aware that their records were accessible outside the practice premises and that community pharmacy staff could access their care and treatment records.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. 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 practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. Clinical staff received annual updates and non clinical staff received updates every two years. The lead carried out an audit of infection control and a risk assessment each year in line with the practice's policy. We also saw that an audit of hand hygiene had taken place and certificates of competency awarded to those that had taken part.

Good

Are services safe?

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 carried out regular checks in line with this policy to reduce the risk of infection to staff and patients, the next check was due in August 2015.

Our last inspection in June 2014 identified that waiting room seating was ripped and had been temporarily repaired but we were told that replacement seating had been ordered. At this inspection we found the seating had not been replaced. We raised this with the registered manager and practice manager who explained why this had not happened. Plans had been passed to redesign the practice which would mean the seating would be redesigned and replaced. We were told the works would commence in August 2015.

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. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers and blood pressure measuring devices.

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, references, qualifications criminal records checks and registration with the appropriate professional body. The practice kept comprehensive records of all checks including regular checks of membership to professional bodies and the immunity status of clinical staff.

We noted that some job roles had been identified as not needing a criminal records check in place such as for clinical staff working alone with patients or undertaking chaperone duties. For example the role of Health Care Assistant had not been included for needing a disclosure and barring check for existing staff as part of ongoing monitoring of employed staff.

We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. Locum staff were used occasionally to cover sick leave. Although locums were usually known to the practice appropriate recruitment checks were done before employment.

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. Data showed that outcomes for patients were good however we noted a relatively low number of practice nursing hours for the practice population.

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. There was an identified health and safety representative who had completed training in the subject.

Identified risks were included on a general risk assessment table. Each risk was assessed and rated with control measures and actions recorded to reduce and manage the risk.

Prescriptions were tracked electronically to enable the GP and staff to identify how many times a repeat could be issued before a review of the patients' needs was required.

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 (used in cardiac emergencies). 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 were within their expiry date. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that the practice had learned from this appropriately.

Good

Are services safe?

Emergency medicines were easily accessible to staff in a secure area of the practice 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 with cause and impact recorded. There was a plan of actions recorded to reduce and manage the risk. Risks identified included power failure, damage to the building and short term or long term loss of the building. The document also contained relevant contact details for staff to refer to. The plan was last reviewed in October 2014.

The practice had carried out a fire risk assessment in 2011 with the Dorset fire and rescue service and had completed and monitored the actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised fire drills there were six appointed and trained fire marshals.

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.

The GPs and nurses we spoke with explained how NICE guidance was discussed at meetings and templates created for their electronic record system to ensure that NICE guidance was incorporated into their patient assessment. For example acute kidney injury was discussed at a clinical meeting; the electronic record template was updated to ensure that clinicians could easily refer to NICE guidelines for use in their patient consultation. It also acted as a reminder to the GP to consider stopping any anti-inflammatory medicines which may put the patient at risk of acute kidney injury. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these 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 GPs told us they led in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support.

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 GPs 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 used to improve care. Staff across the practice took part in monitoring and improving outcomes for patients. The practice had a quality team led by a GP and the quality manager. Information staff collected was then collated by the quality team for statistical analysis and to support clinical audit.

The practice had completed 13 clinical audits in the last 12 months. We looked at a summary of these some of which were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example the practice carried out a complete audit cycle to identify and review patients who had a diagnosis of asthma and:

- were overusing high dose inhaled corticosteroids (>14 inhalers per year).
- were underusing high dose inhaled corticosteroids (<4 years per year).
- to ensure all patients prescribed a high dose inhaled corticosteroid had been reviewed to assess whether a step-down to lower doses could be achieved.

The second audit of the cycle showed that the number of patients under or over ordering inhalers had reduced from 63% to 59%. The number of patients with a documented inhaler technique had increased from 91% to 93% over the recommended standard of 80%.

Other examples included an audit of the minor surgical procedures completed by one of the GPs. This looked at the pre diagnosis, histology and confirmed diagnosis of each patient and an audit of care home patients to ensure they had received a dementia diagnosis recorded as appropriate.

The GPs 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

Good

Are services effective?

(for example, treatment is effective)

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 cephalosporin, an antibiotic. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines. The aim was to alter their prescribing practice to ensure it aligned with national guidelines. In this instance the level of prescribing was very low initially so there was no change recorded after the completed audit cycle.

The practice also used the information collected for the 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 99.3% 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.
- The percentage of patients with hypertension having regular blood pressure tests was better than the national average.
- The dementia diagnosis rate was above the national average.

GPs we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. We saw minutes of doctors meetings which showed that there were regular reviews of QOF and other data.

The practice's prescribing rates were 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. There was a system in place to send up to three letters to patients to encourage them to attend for their annual review.

The practice 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. There was a template on the practice's electronic system to ensure that all the relevant information for the patient is recorded.

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. The practice had coded those patients they had identified as a vulnerable adult to ensure staff were aware of the challenges faced by this group of patients.

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 mandatory courses such as annual basic life support. There was also a schedule for the frequency of refresher training. We noted a good skill mix among the GPs with some having additional qualifications or special interests for example in dermatology and women's health. All GPs were up to date with their yearly continuing professional development requirements and had been revalidated. (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. Although not all staff felt the present appraisal process was effective they were aware that there were planned changes to improve the process for staff. Our interviews with staff confirmed that the practice was proactive in providing training and funding or time for relevant courses, for example one of the practice nurses was studying for their diploma in the management of asthma. As the practice was a training practice, doctors who were training to be qualified as GPs worked at the practice and had access to a senior GP throughout the day for support.

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, cervical cytology, contraception and sexual health. Those with extended roles for example seeing patients with long-term conditions such as asthma or diabetes were also able to demonstrate that they had appropriate training to fulfil these roles.

New staff were supported by the practice through a structured induction process. For example one member of staff told us about their recent induction which had

Good

Are services effective?

(for example, treatment is effective)

included being mentored for four to six weeks with specific training every morning. They continued to liaise with their mentor and had a three month and six month review to ensure their training needs continued to be met.

The practice was trialling the use of personal assistants for GPs. They found that this saved the GPs on average an hour or more each day which increased their availability to see patients. The practice had an actions desk. A member of staff was allocated each day to carry a dedicated telephone that they could be contacted on in order to support the GPs with immediate administrative tasks or practical matters, such as chasing results and referrals, processing prescriptions and other similar duties.

Working with colleagues and other services

The practice worked with other service providers to meet patients' 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. There was a system in place to ensure that all prescriptions or test results were passed to an allocated GP for action if the patient's usual GP was absent from the practice. All staff we spoke with understood their roles and felt the system in place worked well. Details of the GP allocated to cover for any absent GP was recorded in the main office.

Emergency hospital admission rates for the practice were relatively low and the figures for the practice were one of the lowest in the locality and lower than the national figure. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held monthly clinical meetings to discuss patients with complex needs and other vulnerable patients. Health visitors, district nurses and other healthcare professionals attended when appropriate. 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.

Consent to care and treatment

The GPs and nurses we spoke with understood the key parts of the legislation in relation to the Mental Capacity Act 2005 (MCA) and were able to describe how they would implement it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice staff were clear how patients should be supported to make their own decisions and how these should be documented in the medical notes. Although staff were able to describe the principles of the MCA when assessing whether a patient was able to give informed consent, there was no record of specific formal training on this subject.

Care plans were in place for patients with complex needs and 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's end of life template ensured that patients' wishes were recorded such as an agreement of their care plan, their preferred place of death and anticipatory medicines. 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. When verbal consent was given this was

Good

Are services effective?

(for example, treatment is effective)

documented in the patient's record a patient's verbal consent was documented 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.

The pharmacist from the co-located community pharmacy was a contracted member of the practice team and provided clinical services, including medicines reviews and clinics for chronic disease management, for patients at the practice. All pharmacy staff had signed a confidentiality agreement and were bound by the same confidentiality protocols as practice staff. The practice had also created a template for the electronic record system which was completed when a patient gave consent for the pharmacy staff to access their records. Patients who signed up to electronic prescribing with the co-located pharmacy were asked to give their consent for staff to access their medical record and those already signed up were asked opportunistically to sign a consent. The pharmacist asked patients for their consent before accessing the medical records when providing clinical care at the practice The practice could not demonstrate that all patients when choosing to use the on-site community pharmacy were fully consenting and therefore aware that the pharmacy team were able to access their medical records directly.

Health promotion and prevention

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.

The health checks carried out by the practice were recorded and a summary of the results and advice given was handed to the patient. This also gave the relevant contact details for support organisations for example for advice on staying active or for safe drinking (safe levels of alcohol consumption).

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering them help or support for example, the practice referred patients to the community pharmacy which was able to offer smoking cessation advice. Similarly for those patients identified as obese or who required weight management the practice referred them to national weight control programmes and local exercise and healthy living projects.

The practice's performance for the cervical screening programme was 86.79%, which was above the national average of 81.89%. 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 average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 69.2%, and at risk groups 46.84%. These were below national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 87% to 96.5% and five year olds from 90.8% to 95.8%. These were comparable to Clinical Commissioning Group averages.

Patient information leaflets were available. Nurses and GPs described how they were able to print off relevant information for patients during their consultations.

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 published January 2015 and conducted between January and March 2014 and July and September 2014 and a survey of 79 patients who took part in the friends and family test in February and March 2015.

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. Data from the national patient survey showed the practice was rated in line with the national and clinical commissioning group (CCG) average for its satisfaction scores on consultations with doctors. For example:

- 84% said the GP was good at listening to them compared to the CCG average of 91% and national average of 89%.
- 90% said the GP gave them enough time compared to the CCG average of 89% and national average of 87%.
- 93% said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and national average of 95%

A total of 15 patients provided feedback on the day of our inspection they told us what they thought about the practice. Patients 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.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable 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, in another area of the building, to keep patient information private. We saw in the waiting room a notice requesting that patients stay back from the desk when another patient is talking to reception staff. 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, of those patients who completed the national patient survey 90% said they found the receptionists at the practice helpful compared to the CCG average of 90% and national average of 87%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients generally responded positively to questions about their involvement in care planning in line with both the CCG and national averages in this area. For example:

- 85% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 88% and national average of 86%.
- 84% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 85% and national average of 82%.

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.

Staff told us that translation services were available for patients who did not have English as a first language. The practice was aware of the large population of eastern European patients that the practice served. Two members of staff were able to speak Polish and were called upon to support these patients.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area with scores comparable to the average for the CCG and the average nationally. For example:

- 85% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88% and national average of 85%.

Good

Are services caring?

- 92% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 92% and national average of 90%.

The patients we spoke with on the day of our inspection were all positive about the practice and the way all staff treated them with care and concern. They told us that all staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen 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 either by visiting or telephoning the family or by sending a letter. This contact was either followed by a patient consultation at a flexible time and location to meet the family's needs or by giving them advice on how to find a support service, such as steps to wellbeing which was available at the practice.

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. For example the practice had a named GP for each of the care homes where registered patients lived. This had been put in place to provide continuity of care and improved relationships with care home staff.

The practice engaged regularly with other practices in the Poole Bay locality to discuss local needs and service improvements that needed to be prioritised.

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). 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 practice had made changes such as better information for patients with a tidier notice board and the introduction of a patient newsletter.

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 and the availability for same day appointments for those homeless patients who called into the practice and requested a GP consultation. The majority of the practice population were English speaking patients however there was also a large percentage of patients from Europe who worked in the hotel industry and the turnover of these patients was great. The practice had two Polish speaking members of staff but also had access to online and telephone translation services if they were needed.

Staff told us that they had a number of patients who were of "no fixed abode" anybody who came to the practice asking to be seen was registered so they could access services. There was a system for flagging vulnerability in individual patient records.

The premises generally met the needs of people with disabilities. There was a hearing loop for patients who had hearing difficulties. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible to all patients 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. However the reception desk was at a high level which could present a barrier to any patient who used a wheelchair.

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 Friday, for appointments, prescription requests or other queries. The practice was closed between 12 and 2pm on Fridays however patients were still able to contact the practice if necessary as an answer phone message directed them to the practice's urgent telephone phone number. GP's surgeries were held between 8am and 11 am and 3pm and 5.30pm each weekday. Emergency appointments were available throughout the day but specifically each day from 5.30 to 6.30pm. Late night appointments were available each Monday with GP and nurse appointments available between 6.30pm and 8.30pm.

The practice had a duty team working each day. This team consisted of a GP and nurse practitioners. Anybody calling the practice to request an urgent appointment was triaged by staff who had completed training to carry out the role. They were also supported by a set list of questions and a manager who was available to advise them. Staff were able to book an appointment which met the patients' needs, which could be either face to face or for a telephone appointment.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits 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 the practice when it was closed, an answerphone message gave the telephone number they should ring to be connected to the out-of-hours service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions.

The 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:

- 81% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 88% described their experience of making an appointment as good compared to the CCG average of 82% and national average of 74%.
- 64% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 68% and national average of 65%.
- 86% said they could get through easily to the surgery by phone compared to the CCG average of 85% and national average of 74%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. A number of patients we spoke with had made their appointment that day. We also saw that when a patient came into the practice requiring emergency care they were seen within 15 minutes.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns which was in line with recognised guidance and contractual obligations for GPs in England. The practice had a patient liaison manager who was the designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Information about how complaints were dealt with was not available on the practice website although patients were given the opportunity to feedback to the practice through an on line form. A patient information leaflet on complaints was available on request from the practice staff. Patients we spoke with were not all aware of the process to follow if they wished to make a complaint. However none of the patients we spoke with had ever needed to make a complaint about the practice and told us they would be able to ask reception staff who they should contact.

We looked at a summary of complaints received in the last 12 months and found these had been satisfactorily handled and dealt with in a timely way. We saw from meeting minutes that complaints were discussed and lessons learnt recorded and fed back to practice staff. We saw that there was openness and transparency when dealing with the compliant with patients receiving an apology and, if appropriate, information about the changes that have been made at the practice as a result of their complaint.

The practice reviewed complaints regularly at practice meetings to detect themes or trends. We looked at a summary of complaints and discussed with the management team who confirmed that no themes had been identified. The practice produced an analysis of the type of complaints received and the change in the number of complaints year on year. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice's mission statement was displayed on the notice board in the waiting area. 'To provide a healthcare service which is, high quality, user friendly, progressive, multidisciplinary, within the resources available.'

We spoke with members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

The practice had a plan to federate with other practices in the area to improve services for their patients. The practice was researching possible systems to implement to increase access to GPs for patients such as web GP for on line consultations.

There were plans in place to change and improve the practice premises to enable other healthcare professionals to be on site.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. All policies and procedures we looked at had been reviewed recently and were up to date. The infection control policy had been updated in October 2014. Procedures in relation to the policy had been reviewed and updated as required to reflect current guidelines and practice.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and a GP partner was the lead for safeguarding. We spoke with members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager 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. The practice had a quality manager whose role it was to constantly monitor QOF and present the data to GPs and regular meetings. The quality manager worked with one of the GP partners to develop templates for the electronic record system. These were designed to link to relevant National Institute for Health and Care Excellence (NICE) and local commissioners' guidance.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. The practice regularly submitted governance and performance data to the Clinical Commissioning Group.

The practice held monthly clinical meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The patient and staff liaison manager was responsible for human resource policies and procedures. We reviewed a number of policies, which were in place to support staff. These had been reviewed and updated appropriately. All policies were available to all staff on the practice intranet.

Leadership, openness and transparency

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about the practice and felt able to make suggestions for improvements. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Although we noted that a record of a nurses' meeting documented that nurses and healthcare assistants did not always feel informed about changes taking place at the practice.

We saw from minutes that there was a system of meetings was held for various staff groups. 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 confident in doing so and felt supported if they did. We also noted that team away days were also held. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Are services well-led?

Good

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

Staff told us they were well supported by the GP partners and management team and there was always someone to go to for support. Staff were able to guide us to the intranet where they could get information such as policies and procedures.

Practice seeks and acts on feedback from its patients, the 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. The PPG held their own meetings and met with the practice every six months. We spoke with a member of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

We also saw evidence that the practice was collecting and monitoring the results of the family and friends test and had reviewed any comments to see if there were any areas that needed addressing.

The practice had also gathered feedback from staff through staff meetings. 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. The practice had also introduced an online suggestion box on the practice intrasite which encouraged anonymous feedback or suggestions from staff.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training and that they had opportunities to request training that would be beneficial to the practice or to their role.

The practice was a GP training practice and as well as having a GP registrar working at the practice also took medical students from a nearby university in order for them to gain experience and knowledge of general practice.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example a patient collapsed in a public area and practice staff needed to provide emergency treatment. Following the significant event all practice staff were involved in the event analysis and provided suggestions to improve what had been the successful handling of the event. Equipment was purchased and made more accessible and the additional needs of the patient were taken into consideration such as respecting their privacy and dignity with the use of a curtain.

Another significant event concerning a delayed diagnosis had resulted in a number of changes to practice systems to mitigate any future risks. For example, a template had been designed in order to alert GPs to current guidance and one of the GPs had attended a conference on the subject and disseminated information to colleagues.