Wareham 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

Wareham Surgery was located at Streche Road, Wareham, Dorset, BH20 4PG. The practice had no branch surgeries, nor did it dispense medicines. At the time of our inspection there were approximately 7,900 patients registered at the service.

Wareham Surgery was registered with the Care Quality Commission to provide the following regulated activities:

- Diagnostics and Screening
- Maternity and Midwifery services
- Surgical Procedures
- Treatment of disease, disorder or injury

We spoke with patients and staff employed at the practice during our inspection. Patients spoke positively about the staff employed at the practice and the level of care they received. Patients told us they felt the practice was safe. They told us that care was given to them in accordance with their wishes following a discussion about different treatment options available. Patients told us they felt the practice was responsive to their needs. For example, patients said that an urgent appointment could always be obtained on the day they contacted the practice. This was reflective of the information provided of the practice website and within the practice welcome pack.

As part of our inspection we took a GP as part of our team. They evidenced the practice was effective in the way it provided to care to people. In addition to the evidence obtained by our inspection team, the supporting data and documentation we reviewed about the practice demonstrated the practice performed very well when compared with all other practices within the Dorset Clinical Commissioning Group (CCG) area.

We saw that the practice was well led, with a clear leadership structure in operation. The staff we spoke with spoke highly of the management within the practice and told us they felt supported in their roles.

The supporting information reviewed during our inspection demonstrated the practice had appropriate systems in place that monitored the safety and effectiveness of the care provided.

During our inspection our inspection team spoke with the provider about patient groups. The patient groups were;

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Overall we found the service was safe. Patients we spoke with told us they felt safe at the practice and felt confident in the care provided by the clinical staff at the practice.

The practice had systems to help ensure patient safety. For example, the practice attended monthly multi-agency Gold Standard Framework (GSF) meetings to share information about patients who required palliative care.

We saw that suitable arrangements were in place which ensured patient safety during times of staffing challenges, and overall recruitment procedures and checks were completed as required.

There was a system in operation that encouraged and supported staff to learn from any significant events or incidents. There were suitable safeguarding policies and procedures in place that helped protect children and adults who used the practice from the risk of abuse.

The practice had risk assessments and systems that minimised potential risks to the health safety and welfare of the patients, staff and visitors who used the practice. There were suitable arrangements for the management of medicines.

The practice was observed to be clean. We found suitable arrangements were in place that ensured the cleanliness of the practice and there were effective systems in place for the retention and disposal of clinical waste.

Are services effective?

Overall we found the service was effective. Supporting data obtained both prior to and during the inspection showed the practice was effective.

The provider had a clinical audit system in progress and most audits had completed the full audit cycle. We saw that care and treatment was delivered in line national best practice guidance.

The provider worked closely with other services to achieve the best outcome for patients who used the practice.

Staff employed at the practice received appropriate training and appraisal. GP partner's appraisals had been completed annually.

We saw that the practice had extensive health promotion material available within the practice and on the practice website.

Summary of findings

Are services caring?

Overall we found the service was caring. We spoke with patients who spoke positively of the care provided at the practice. Documented feedback seen from the practice quality assurance system was also complimentary.

Patients told us they felt they had sufficient time to speak with their GP or a nurse and said they felt well supported both during and after and consultations, or any subsequent diagnosis and treatment.

The provider told us patients who required urgent appointments were seen the same day, and patients we spoke with told us they would be seen if required. The management of appointment time availability by the practice had improved and now ensured that additional appointments were available on different days of the week.

Are services responsive to people's needs?

Overall we found the service met people's needs. There was an active patient forum group and virtual patient forum group that communicated by e-mail.

We saw there was a clear complaints policy that was available within the service and on the provider's website. The provider had responded appropriately and in the time frame stated to any complaints received.

The provider actively promoted feedback to listen to people's views by ensuring that feedback forms were openly available within the practice and people were encouraged to use the National Health Service Choices website.

Patients told us they felt they had sufficient access to the practice and appointments could be made by phoning the practice, attending in person or booking thorough the provider's website.

Are services well-led?

Overall we found the service was well led. There was a clear leadership structure in operation. Both clinical and non-clinical staff demonstrated they were clear about their responsibilities and how and to whom they should escalate any concerns.

Staff spoke positively about their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open culture.

Summary of findings

There was a clinical auditing system in operation with risk management tools being used to minimise any risks to patients, staff and visitors. There was an appropriate clinical governance system operated by the provider that ensured lessons were learned from events.

The provider had ensured that during times of staffing number reductions or projected reductions, sufficient physical and financial resources had been forecast to ensure patient safety or service quality was uncompromised.

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
Overall, we found the practice provided routine care to older patients.

The practice offered blood pressure monitoring and general well man/woman consultations.

Appropriate systems ensured flu vaccination programmes were completed and effective treatments and on-going support for those patients identified with the early signs of dementia were available.

A current project being undertaken by the practice aimed to explore what services could be developed and maintained for the elderly population in the area over the next 20 years.

People with long-term conditions
Overall, we found the practice provided routine care to patients with long term health conditions.

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

We found patients with long term illnesses had their condition and medication reviewed when required.

Research by the practice had established the need for a diabetic outreach service to be created.

Mothers, babies, children and young people
Overall, we found the practice provided routine care to mothers, babies, children and young people.

Expectant mothers attended the practice and were seen for their initial antenatal assessment and then referred to the midwife who held clinics on site.

The practice worked closely with community midwives and health visitors.

Appropriate systems were in place for the identification and referral of safeguarding matters that related to children and young people.

The working-age population and those recently retired
Overall, we found the practice provided routine care to the working age population and recently retired patients.

Summary of findings

A telephone triage was available for patients at work and flexible appointment times were available throughout the week.

Suitable travel advice was available from the clinical staff within the practice and the supporting information within the waiting areas.

The practice had responded following a completed audit cycle of Accident and Emergency attendances by working patients and increased the opening hours of the practice.

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

Overall, we found the practice provided routine care to people in vulnerable circumstances.

People within vulnerable communities, for example the travelling community or the homeless were registered at the practice. Primary care was provided when required and liaison was sought with other professionals when required.

Vaccinations were offered when required and an appropriate system for people who may be vulnerable due to their mobility was evident.

People experiencing poor mental health

Overall, we found the practice offered routine care to people experiencing a mental health problem.

Routine care appointments for patients experiencing a mental health problem were available and advanced bookings could be made if required.

The practice evidenced they were responsive in making referrals for mental health concerns through patient feedback and records.

Liaison was undertaken with external agencies, for example the mental health crisis team, when required.

Summary of findings

What people who use the service say

We spoke with eight patients within the practice on the day of our inspection and the chairperson of the patient forum group. The feedback from patients and the forum group chairperson was very positive. Patients told us about their experiences of care and praised the level of care and support they received at the practice. The chairperson of the patient forum group spoke highly of the interaction and involvement received from all GP partners at the practice.

The practice had provided its patients with information about the regulatory function of the Care Quality Commission prior to the inspection. This included a display board in a prominent position in the waiting area of the practice and had made comment cards available for patients to share their experience with us. Patients at the practice had elected not to use the Care Quality Commission comment cards, but we saw from previous documented feedback obtained from the practices own quality assurance document that people gave very positive feedback.

Areas for improvement

Action the service COULD take to improve

Some application forms demonstrated periods of a break in the staff members employment history that had not been explored.

Good practice

Our inspection team highlighted the following areas of good practice:

The practice was a strong advocate of primary care research and undertook a number of research projects led by the research champion in the practice. We saw that a recent study into the treatment of acute cough had been completed and in addition we saw written evidence of success in recruitment to other studies. The practice was in receipt of additional funding by university research departments in primary care that enabled the research champion to continue this work without jeopardising practice income.

A project was currently being undertaken at the practice following an assessment of the facilities and services for the elderly that are available in Purbeck area of the community. It included an assessment of the services available within the local community hospitals. The aim was to explore what services could be developed and maintained for the next 20 years in the area. Within this project there was an intention to provide more services closer to home and more rehabilitation services in the local community or at home. The aim was to incorporate some hospital admission avoidance and the ability for step-down care when patients left acute hospitals.

In relation to ophthalmology (diseases of the eye), previous audits had shown that ophthalmology referrals were some of the more frequent referrals locally. Following an initiative within the practice, a community ophthalmology clinic had now been planned to commence in June 2014. This would allow patients to be seen and avoid having to travel to Poole or locations a further distance away. This clinic would run in conjunction with a consultant clinic for advice and additional triage. This could reduce the pressure on consultant appointments and allow more timely assessments.

The practice had identified that patients with a diagnosis of diabetes unable to leave their home did not receive the same opportunities for follow up care. As a result of this,

discussions were being undertaken to establish if a diabetic outreach service could be created. This would ensure these patients needs were reviewed and that the same level of service was provided as at the practice.

Locally, alcohol services and advice were regarded as a priority by both the local council wellbeing board and Dorset Clinical Commissioning Group. A number of healthcare professionals, which included members of Wareham Surgery, had attended workshops to learn how to do a brief intervention when they encountered a patient with alcohol misuse problems. There had been meetings across the services and network to develop referrals and also to create understanding about the ways in which different teams could work together. The aim is that this work will be developed further in the future to lessen the impact on alcohol problems within the community locally.

The practice had systems to help ensure patient safety. For example, the practice attended monthly multi-agency Gold Standard Framework (GSF) meetings to share information about patients who required palliative care.

Wareham Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team also included a second CQC inspector, a GP and a governance specialist.

Background to Wareham Surgery

Wareham Surgery was located at Streche Road, Wareham, Dorset, BH20 4PG . The practice had approximately 7,900 people registered at the time of our inspection. The practice provided services to patients from Wareham and the local surrounding villages. The practice was a single site practice with no branch surgeries and did not dispense medicines.

The practice provided services to a diverse population age group, the service was provided by the six GP partners who are registered at Wareham Surgery. The practice had one senior nurse employed, two healthcare assistants, a practice manager and additional administration staff. The practice was open between 08.30am until 6.30pm Monday to Friday except on bank holidays. The practice closed daily between 1pm and 2pm however patients could still contact the practice via the telephone during this period in the event of an emergency. Routine appointments were available daily and urgent appointments would be facilitated on the day of the patients request. The practice also offered later appointments for patients on Monday, Tuesday and Thursday evenings.

Why we carried out this inspection

We inspected this 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

Before conducting our announced inspection of Wareham Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England and Clinical Commissioning group. We requested information and documentation from the provider which was sent to us in timely manner.

We carried out our announced visit on 30 May 2014. During our visit we spoke with a range of staff including the GP who was the registered manager for Wareham Surgery, the senior practice nurse and a member of the administrative staff. We also spoke with patients who used the service. We looked at documentation that related to the management of Wareham Surgery and patient records during our inspection. We observed staff interactions with patients and made observations throughout the internal and external areas of the building.

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?

Detailed findings

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

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

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

Are services safe?

Summary of findings

Overall we found the service was safe. Patients we spoke with told us they felt safe at the practice and felt confident in the care provided by the clinical staff at the practice.

The practice had systems to help ensure patient safety. For example, the practice attended monthly multi-agency Gold Standard Framework (GSF) meetings to share information about patients who required palliative care.

We saw that suitable arrangements were in place which ensured patient safety during times of staffing challenges, and overall recruitment procedures and checks were completed as required.

There was a system in operation that encouraged and supported staff to learn from any significant events or incidents. There were suitable safeguarding policies and procedures in place that helped protect children and adults who used the practice from the risk of abuse.

The practice had risk assessments and systems that minimised potential risks to the health safety and welfare of the patients, staff and visitors who used the practice. There were suitable arrangements for the management of medicines.

The practice was observed to be clean. We found suitable arrangements were in place that ensured the cleanliness of the practice and there were effective systems in place for the retention and disposal of clinical waste.

Our findings

Safe Patient Care

Staff were aware of the provider's significant event reporting process and how they would escalate concerns within the practice. Staff also demonstrated knowledge that following a significant event, the practice would undertake a Significant Event Analysis (SEA) to establish the full details of the incident and the full circumstances surrounding it.

Learning from Incidents

We looked at the significant event reporting process and the subsequently produced SEA documentation. The practice used an identical standard printed document for all of the significant event reports, and this was completed by a GP. The registered manager told us that the clinicians discussed these significant events when they were identified, and also formally every quarter at a meeting.

We reviewed the supporting agenda from the SEA meeting held in March 2014. The agenda showed that significant events for that quarter period included, for example, a wrongly administered vaccine. We saw from the SEA document attached to the meeting agenda that details of the event, the issues identified, and the learning outcomes had been documented. Any subsequent actions required to reduce the risk of reoccurrence were documented and showed what actions were to be completed and by whom. This showed the provider demonstrated transparency in the recording or significant events and ensured that matters were investigated and learning outcomes were identified and disseminated to staff. We did see however that the content and descriptive information surrounding different recorded events was variable on different SEA documents dependant on the author. In addition, although when we spoke with staff they could identify learning outcomes from individual SAE's, this was not always fully recorded on the supporting documentation.

Safeguarding

There was a GP partner who had a lead responsibility for both adult and child safeguarding. We saw they had been trained up to the appropriate level (level 3). There were appropriate policies in place to direct staff on when and how to make a safeguarding referral. The policies included information on external agency contacts, for example the local safeguarding team. We saw within a communal staff area of the building that additional safeguarding

Are services safe?

information was displayed. This meant staff at the practice had open access to information if they wished to report a safeguarding concern. The staff we spoke with told us they had received safeguarding training. They told us they were aware of whom the safeguarding leads were and demonstrated knowledge of how to make a referral or escalate a safeguarding concern internally.

We saw from patient records that where applicable, a vulnerable adult or an at risk child had an icon on their electronic patient record screen to advise the clinician of their status. This would ensure that in the event the vulnerable adult or at risk child was seen by different clinicians, all would be aware of their circumstances and this important information would not be lost. A documented safeguarding referral letter was seen during the inspection that demonstrated the practice had made a referral.

Monitoring Safety & Responding to Risk

We saw the practice had a number of risk assessments in place to ensure the health and safety of patients, visitors and staff members. These included risk assessments related to fire hazards and health and safety. The practice had a suitable business continuity plan that documented their response to any prolonged period of events that may compromise patient safety or the delivery of its services.

The provider evidenced that future risks or impacts to the service were identified at the earliest opportunity. For example, the minutes of a practice meeting held in May 2014 showed the provider had identified that a new housing development in the local area will raise the population of the area and have an impact on patient numbers at the practice. It was identified that upon completion of the development an additional 600 people could be registered at the practice and that this may have an impact on staffing level requirements.

Medicines Management

There was no dispensary at Wareham Surgery; prescribed medicines were collected by patients from locations in the local community. We discussed the procedures in place at the practice for medicines management and safety alerts relating to medication. Overall, the practice had an appropriate system in place for dealing with medical alerts. The practice lead attended locality meetings and medication alerts were discussed weekly at practice meetings. A search was conducted of patient medication records against alerts issued for certain medicines by the Medicines and Healthcare products Regulatory Agency (MHRA) or the European Medicines Agency (EMA). It was established that two patients still received a certain medicine no longer recommended for repeat prescribing. It was however established the medicine may have still been prescribed due to its other positive values. The provider stated this would be reviewed in accordance with MHRA guidance in the near future.

There was a secure area in which Controlled Drugs (CD's) were held. A check of the physical stock of the CD's within the practice was found to be correct and accurate. We saw that medicines requiring cool storage were stored correctly within refrigerators and fridge temperature data showed that the refrigerators operated within safe levels.

The management of uncollected prescriptions showed uncollected prescriptions were retained by the administrative staff for a maximum of three months before being returned to the practice manager and subsequently to the GP. This was discussed with the practice manager and registered manager who agreed it would be safer if the frequency of monitoring uncollected prescriptions was increased to monthly to avoid important, uncollected prescriptions going unrecorded for such a significant period of time.

Cleanliness & Infection Control

The provider had an infection control policy and a dedicated infection control lead. The treatment and consulting rooms were clean, tidy and uncluttered. The clinical rooms of the practice were stocked with personal protective equipment which included a range of disposable gloves, aprons and coverings. This enabled clinical staff to use and dispose of this equipment when examining patients which reduced the risk of cross infection. We saw that antibacterial gel was available in the reception area for patients to use upon entering the practice. In addition, this gel was available next to the automated arrivals machine which was primarily the first area patients would go when they entered the practice. We saw within communal areas, for example the public toilets, that antibacterial hand wash and paper towels were available. Within the communal toilets, the flush system for the toilet was sensor operated that avoided people having to touch the flush with their hands. This reduced the risk of cross infection.

We saw there was an appropriate system for safely handling, storing and disposing of clinical waste. Clinical

waste was stored securely in a dedicated secure area whilst awaiting its weekly collection from a registered waste disposal company. There were cleaning schedules in place and an infection control audit system was in operation. Treatment rooms had hard flooring to simplify the clearance of spillages if required so spillages were easily cleared up. The staff training record showed that most staff had received updated training in infection control.

Staffing & Recruitment

Overall, we found that recruitment procedures were safe and the staff employed at the practice had undergone the appropriate checks prior to commencing employment. We looked at the recruitment files of four staff members employed at the practice within the last 12 months. We found the practice had ensured that most of required checks required for staff had been completed or they were in the process of being completed at the time of our inspection. We found that where required, Disclosure and Barring Service (DBS) checks had been completed. The DBS check ensures that any person previously barred from working with vulnerable groups is identified. We found references had been obtained for staff members, and for clinical staff a check of the staff member's Nursing and Midwifery Council (NMC) status was completed. Some application forms demonstrated periods of a break in the staff members employment history that had not been explored as required. This meant the practice had not ensured a suitable explanation of a break in a staff members employment history had not been obtained.

Dealing with Emergencies

There was a rotational system in operation that ensured one of the nominated GP partners would respond to emergency situations, for example emergency home visits. Within the practice, the provider had ensured appropriate equipment was available to support patients in the event an emergency, for example if a person suffered cardiac failure. We saw that an Automated External Defibrillator was held within the practice, together with emergency drugs for other possible emergencies. This equipment and emergency drugs were located in a near central communal area of the practice to allow any member of clinical or non-clinical staff to obtain the equipment if requested or required.

Equipment

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

We saw that emergency medicines within the practice were within their expiry date. The provider had an effective system in operation that monitored the dates of emergency medicines and ensured they were discarded and replaced as required.

Are services effective?

(for example, treatment is effective)

Summary of findings

Overall we found the service was effective. Supporting data obtained both prior to and during the inspection showed the practice was effective.

The provider had a clinical audit system in progress and most audits had completed the full audit cycle. We saw that care and treatment was delivered in line national best practice guidance.

The provider worked closely with other services to achieve the best outcome for patients who used the practice.

Staff employed at the practice received appropriate training and appraisal. GP partner's appraisals had been completed annually.

We saw that the practice had extensive health promotion material available within the practice and on the practice website.

Our findings

Promoting Best Practice

We saw several examples where care and treatment followed national best practice and guidelines. For example, emergency medicines and equipment held within the practice followed the guidance produced by the Resuscitation Council (UK). The practice followed the National Institute for Health and Clinical Excellence (NICE) guidance and we saw that where required, guidance from the Mental Capacity Act 2005 had been followed. For example, we saw documentation that showed a best interest decision meeting had taken place for a person with a cognitive impairment that required medical treatment. We saw that a documented mental capacity assessment had been completed and a best interest assessment form and checklist had been completed during the decision making process.

The practice used the quality outcome framework (QOF) to measure their performance. QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their practices. The QOF data for this practice showed that it generally achieved high or very high scores in areas that reflected the effectiveness of care provided. The local Clinical Commissioning Group (CCG) data demonstrated that the practice performed well in comparison to other practices within the CCG.

Management, monitoring and improving outcomes for people

The practice was a strong advocate of primary care research and undertook a number of research projects led by the research champion in the practice. We saw that a recent study into the treatment of acute cough had been completed and in addition we saw written evidence of success in recruitment to other studies. The practices success has led to some additional funding by university research departments in primary care that enabled the research champion to continue this work without jeopardising practice income.

The practice undertook a number of clinical audits. We looked at three during the course of our inspection visit. One audit we saw was of medication used to treat depression and mental health disorders. The audit was in relation to the prescribing of the medication and the effects its interactions had with other medications. This was an

Are services effective?
(for example, treatment is effective)

audit which included a final audit to complete the required cycle in line with General Medical Council (GMC) guidance for appraisals. Another audit reviewed was on cervical screening which also was fully completed and reviewed with a follow-up.

A project was currently being undertaken at the practice following an assessment of the facilities and services for the elderly that are available in Purbeck area of the community. It included an assessment of the services available within the local community hospitals. The aim was to explore what services could be developed and maintained for the next 20 years in the area. Within this project there was an intention to provide more services closer to home and more rehabilitation services in the local community or at home. The aim was to also incorporate some admission avoidance and the ability for step-down care when patients left acute hospitals.

In relation to ophthalmology (diseases of the eye), previous audits had shown that ophthalmology referrals were some of the more frequent referrals locally. Following an initiative within the practice, a community ophthalmology clinic had now been planned to commence in June 2014. This would allow patients to be seen and avoid having to travel to Poole or locations a further distance away. This clinic would run in conjunction with a consultant clinic for advice and additional triage. This could reduce the pressure on consultant appointments and allow more timely assessments.

The practice had identified that patients with a diagnosis of diabetes who were unable to leave their home were not receiving the same service as patients who could attend the practice in some of the local areas. As a result of this, discussions were being undertaken to establish if a diabetic outreach service could be created. This could ensure these patients needs were reviewed and that the same level of service was provided as at the practice.

Locally, alcohol services and advice were regarded as a priority by both the local council wellbeing board and Dorset Clinical Commissioning Group. A number of healthcare professionals, which included members of Wareham Surgery, had attended workshops to learn how to do a brief intervention when they encountered a patient with alcohol related problems. There have been meetings across the services and network to develop referral processes and also to create understanding about the ways in which different teams could work together. The aim is that this work will be developed further in the future to lessen the impact on alcohol problems within the community locally.

Staffing

All of the clinicians in the practice participated in the near mandatory appraisal system leading to revalidation over a five-year cycle. We saw these appraisals had been appropriately completed but at the time of our inspection, none of the GP partners had been revalidated as none of the GP partner's had yet reached a five-year assessment point. The registered manager was due to be revalidated in the next few months. We spoke with other clinical staff, for example the senior practice nurse, and non-clinical staff about appraisal. All told us they received an appraisal and we saw documented evidence to confirm this.

We saw the staff training record supplied to us by the practice manager. This showed that training such as safeguarding, infection control, fire safety and information governance had been undertaken by staff. Some training that had been undertaken by staff was not reflected on the training record. For example, the training record showed that one of the GP partners had not undertaken cardiopulmonary resuscitation (CPR) training as required. It was established that this GP had completed their training at an external venue but this had not been recorded. This meant there was a risk that training that required updating may not be identified.

Working with other services

The provider actively attended Gold Standards Framework (GSF) about end of life patient care meetings on a monthly basis. This meeting was attended by the GP partners, Macmillan nurses, staff community matron district nurses and usually a social worker. The meeting primarily dealt with patients who had palliative care needs and other patients who had particular needs related to the GSF.

Particular reviews had been completed in liaison with the out of hour's service. During our inspection we followed special notes and documentation that related to out of hours care through to the patient record and compared these with the faxed pro forma letter to the out of hours provider. Special notes were clear and thorough and provided valuable information to the provider. This meant that the provider had ensured important medical information from a third party agency had been captured and recorded.

Are services effective?

(for example, treatment is effective)

Health Promotion & Prevention

The practice did not screen all new patients. The registered manager told us this was found to be relatively non-productive. However, new patients with a higher level of disorders or diseases on the screening assessment or an identified higher level alcohol or smoking risk were reviewed in the practice by the practice nurse or GP if required.

There were a range of leaflets and information documents available for patients within the practice and on the provider's website. We saw that within the practice, leaflets were available about mental health issues, smoking cessation, diet and how to live a healthy lifestyle. The practice website had links for people to follow on how to obtain urgent medical advice and support, quick advice on common ailments and a useful guide to coughs, colds, earaches and a sore throat. These links were on the home page of the providers website and very simple to locate as they had been prominently placed.

Within the practice we found the provider had a private room entitled the 'Health Zone' available for patients. Within this room, patients could take their own blood pressure, their height and their weight. There were forms supplied by the practice for people to fill out the results of any recordings or measurements they took so they could hand them to their GP if they chose to.

Are services caring?

Summary of findings

Overall we found the service was caring. We spoke with patients who spoke positively of the care provided at the practice. Documented feedback seen from the practice quality assurance system was also complimentary.

Patients told us they felt they had sufficient time to speak with their GP or a nurse and said they felt well supported both during and after and consultations, or any subsequent diagnosis and treatment.

The provider told us patients who required urgent appointments were seen the same day, and patients we spoke with told us they would be seen if required. The management of appointment time availability by the practice had improved and now ensured that additional appointments were available on different days of the week.

Our findings

Respect, Dignity, Compassion & Empathy

Patients we spoke with told us they felt well cared for at the practice. They told us they felt they were communicated with in a caring and respectful manner by both clinical and non-clinical staff at the practice. We saw that patient confidentiality was respected within the practice. The waiting area had sufficient seating and was located away from the main reception desk which reduced the opportunity for conversations between reception staff and patients to be overheard. We made numerous observations throughout the day of reception staff communicating pleasantly and respectfully with patients. The incoming telephone lines to the practice were located in the rear of the reception area in a separate room, so no conversations between the reception staff and patients were audible in the waiting room.

We spoke with a member of the reception staff who told us that if a patient required, an additional room was available to speak with reception staff privately. Patients we spoke with were aware of this room but told us they had not required the use of it. A member of reception staff told us that on occasions they had invited people into the room to protect their privacy. An example of this provided by the staff member was when a patient who suffered from hearing difficulties was speaking loudly in the reception area, they invited the patient to a different room to ensure the conversation about their medical conditions remained private.

We made observations that consultations and treatment with clinical staff were completed when treatment room doors were closed. Patients told us they felt all conversations with clinical staff were confidential and told us conversations were always conducted within the treatment room behind a closed door. Within consultation and treatment rooms, we saw windows were obscured with blinds or curtains to ensure people's privacy. The GP partner's consultation rooms were fitted with dignity curtains so if a person was required to undress they could do so in privacy.

We found that care for patients with palliative care needs were discussed monthly at Gold Standard Framework (GSF) meetings and these were attended by the GP partners, Macmillan nurses, staff community matron district nurses and usually a social worker. The meeting discussed patient

Are services caring?

care and the planning of end of life care. When we reviewed open source information before our inspection, we found a person had left a review on the NHS choices website which praised the end of life care a family member had received from the practice.

Involvement in decisions and consent

Patients we spoke with told us they were able to express their views and said they felt involved in the decision making process about their care and treatment. They told us they have sufficient time to discuss their concerns with their GP. Patients said that different treatment options were discussed with them, together with the positive and possible negative effects the treatment may have. Patients said that where required, their GP or the practice nurse would give them information on their condition and treatment options. The senior practice nurse showed us the practice computer system and the information leaflets that could be easily printed from it. In addition to the practice computer system, information leaflets were also obtained from recognised internet web sites.

Patients told us that nothing was undertaken without their agreement or consent within the practice. We spoke with the practice manager about manager about any language interpretation services they have access to should a situation arise and consent to treatment was required from a person whose first language was not English. The practice manager explained that problems of this nature do not routinely arise, however they showed us they had immediate access to a language interpretation service should the situation arise. We saw from supporting documentation that where people did not have the mental capacity to consent to a specific course of care or treatment, the provider had acted in accordance with the Mental Capacity Act 2005.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

Overall we found the service met people's needs. There was an active patient forum group and virtual patient forum group that communicated by e-mail.

We saw there was a clear complaints policy that was available within the service and on the provider's website. The provider had responded appropriately and in the time frame stated to any complaints received.

The provider actively promoted feedback to listen to people's views by ensuring that feedback forms were openly available within the practice and people were encouraged to use the National Health Service Choices website.

Patients told us they felt they had sufficient access to the practice and appointments could be made by phoning the practice, attending in person or booking thorough the provider's website.

Our findings

Responding to and meeting people's needs

The practice had an open waiting area and sufficient seating. The reception and waiting area had sufficient space for wheelchair users and additional seating or people who had difficulty sitting or who had reduced mobility. There was a reception area with ample seating. The reception staff were pleasant and respectful to the patients.

Patients we spoke with told us they felt the practice were responsive to their individual needs. They told us that appointment times were generally available to suit them, and although the people we spoke with had not required a home visit, they felt confident the service would meet their needs if required. We asked people about the practice responding to any complaints or concerns they had. People we spoke with told us they had not made any complaints nor did they have any concerns, however they felt confident they would be listened to. We saw from the provider's complaint responses that complaints were responded to in an appropriate and timely manner.

We saw that within the practice, there had been staffing challenges with GP and nursing staff shortages over the previous 12 month period prior to our inspection. The practice had responded to staff shortages by recruiting locums and bank nurse staff. In addition, we saw that the provider had ensured additional funding had been made available for the new financial year to help ensure sufficient staffing numbers were maintained.

We looked at the process of patient referrals and reviewed a number of referrals. All were found to involve the patient and were adequately detailed for a suitable referral to secondary care. Patients we spoke with told us that any referral to secondary care had always been discussed with them and actioned in a way they had expected.

The practice had an active patient forum group and a virtual patient forum group that communicated by e-mail. We spent time during the morning of our inspection speaking with the chairperson of the patient forum group about the provider's engagement and responsiveness. They spoke highly of the interaction with the GP partners at the practice and stated they all attended patient forum meetings at different times.

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Patients told us that if they required an urgent appointment they would always be seen on the day they requested an appointment. This was discussed with the registered manager who confirmed that a patient would always be seen on the day if the patient required an urgent appointment. We spoke with two patients during the inspection process who told us they had contacted the practice on that day and had obtained an appointment shortly after their telephone call and that this was normal for the practice.

The appointment system at the practice had been developed over time by the provider and now factored in space which allowed for when appointments over-ran. Patients could book appointments by either telephoning the practice, attending the practice in person or using the provider's on-line booking service for future appointments, these could be booked up to six weeks in advance. People we spoke with told us they were able to access the practice when they needed. The provider's website gave detailed information about the appointment system within the practice and when specific times were designed to meet people's needs. The practice also had two late clinics to assist the working population in accessing their GP.

In addition to the provider's website, a practice information welcome document for patients that was available in the reception area contained appropriate information on the services provided by the practice. It contained information on staff employed at the practice, opening times, appointments, home visits, out of hours care and telephone triage services.

Concerns & Complaints

We saw the provider had an effective complaints procedure in place. In addition, the provider had ensured that facilities were openly available for patients to give feedback at appointments should they so wish.

Information on how to raise a complaint or concern was displayed within the practice and information was also available on the provider's website. The practice complaint information for patients described how people should raise their complaint in the first instance, and the formal process that would then be undertaken following the submission of the complaint and the timescales in which the practice would respond. The complaints leaflet also gave appropriate information of other regulatory bodies to which patients could complain, for example NHS England local team. Information on how to obtain advocacy for an NHS Complaints was available. Information was also documented of how patients could contact the Care Quality Commission should the need arise.

The registered manager had the lead responsibility for dealing with complaints within the practice. We looked at a sample of complaints received at the practice and saw that all responses had been made in accordance with the practice policy and information leaflet timescales. We saw from the Significant Event Analysis (SEA) meeting agendas that patient complaints were discussed with GP partners and staff to ensure learning had taken place from the complaint and where applicable the risk of repetition had been minimised.

Are services well-led?

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

Summary of findings

Overall we found the service was well led. There was a clear leadership structure in operation. Both clinical and non-clinical staff demonstrated they were clear about their responsibilities and how and to whom they should escalate any concerns.

Staff spoke positively about their employment at the practice. They told us they were actively supported in their employment and described the practice as having an open culture.

There was a clinical auditing system in operation with risk management tools being used to minimise any risks to patients, staff and visitors. There was an appropriate clinical governance system operated by the provider that ensured lessons were learned from events.

The provider had ensured that during times of staffing number reductions or projected reductions, sufficient physical and financial resources had been forecast to ensure patient safety or service quality was uncompromised.

Our findings

Leadership & Culture

We spoke with clinical and non-clinical staff during the inspection process. All spoke highly of their employment at the practice and the standard of leadership they worked under. All said that the GP partners were approachable and said there was a strong team ethos throughout the practice. All of the staff we spoke made positive references to the open culture within the practice.

Governance Arrangements

We found there were suitable systems in operation to manage governance of the practice. The practice had structured meetings that ensured information was shared. For example, a business meeting was held weekly that involved the GP partners, the practice manager and the practice nurse. Clinical issues and matters related to the running of the practice such as staffing were discussed. This ensured matters that may have an impact on patient care and safety were discussed to ensure awareness.

There were a bi-weekly staff meetings held over a lunch period and a more formal staff meeting held monthly which was minuted by the practice manager. We saw the minutes for the meeting held in May 2014. They showed that matters such as staffing, infection control, Quality Outcome Framework (QOF) data and medication alerts were discussed. The minutes also recorded that where an action was agreed to be completed by a staff member by a specific date, this was recorded on the minutes. This helped monitor the completion of actions important to the practice.

We also saw that other meetings specific to various functions of the practice were held. For example, there was a palliative care meeting every month, administrative team meetings and the patient forum meetings were held approximately every three months.

Systems to monitor and improve quality & improvement

The quality of care was reflected in the practice achievements against the Quality Outcomes Framework (QOF). The practice was approximately 50 points below the maximum and this was a good achievement. Although there was no particular QOF lead in the practice, each clinician and practice nurses contributed in the practice achieving its current achievements.

Are services well-led?

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

The clinical auditing system assisted in driving improvement and the practice undertook additional auditing. An example of this was the practice had audited attendances by their patients at Accident and Emergency (A&E). The findings were that due to the rural location of the practice, some patients registered at the practice who worked in urban areas found that attending walk-in or A&E departments was more convenient at the end of the working day. To improve this patient outcome, opportunities for flexible appointment times with all of the GP partners in the practice had been increased. All GP partners offered at least one hour per week of extended hours for appointment times which had increased the opportunities for professional working patients or others to attend at flexible times.

Patient Experience & Involvement

The practice recognised the importance of patient feedback and ensured that appropriate facilities were available and advertised for patients to see. In the reception area there were satisfaction surveys available. They sought the feedback of patients in relation to the time they had for an appointment, if patents felt listened to, if they received sufficient information, and their overall patient satisfaction. We looked at a sample of the surveys that had been submitted to the practice. All showed very high levels of satisfaction which was mirrored during our conversations with patients. In addition to their own internal system, the provider encouraged patients to submit feedback on the national NHS Choices website. We studied this feedback as part of our pre-inspection planning. The general feedback on the website was very positive about the practice. There was one piece of negative feedback, however the informant was anonymous so the information could not authenticated.

The provider and patient forum also recorded patient experience in an annual survey. The latest survey completed during 2013 was to establish, for example, how patients booked appointments, how repeat prescriptions were obtained or what information they wished to be displayed on the television monitor within the waiting area. In addition to this, within the survey patients who had a chronic condition were asked to rate the care they received at the practice. We saw that of the 164 patients who responded to the survey, 94.5% rated their care as either excellent, very good or good.

Learning & Improvement

Staff demonstrated awareness of the incident reporting policy. Any significant events or incidents had been recorded on the provider's standardised document. The significant event was discussed at or near the time it was reported, and also at quarterly meetings in the form of a Significant Event Analysis (SEA). The SEA meetings involved the GP partners and any staff appropriate to the matter to the significant event being analysed. This could include both clinical and non-clinical staff. Staff we spoke with told us the SEA meetings were valuable and that the learning from these meetings reduced the risk of the event or incident occurring again.

Identification & Management of Risk

We saw the provider had systems in place to identify and manage risks to the patients, staff and visitors that attended the practice. We saw risk assessments had been completed for the identified health and safety risk relating to the building. In addition, a fire risk assessment had been completed and we saw that fire systems and equipment were subject to regular testing. The practice was protected by an intruder alarm system and we saw this was also subject to periodic testing and servicing. The provider had a suitable business continuity plan to manage the risks associated with a significant disruption to the service. For example, if the electricity supply failed or if the telephone lines at the practice failed to work.

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

Overall, we found the practice provided routine care to older patients.

The practice offered blood pressure monitoring and general well man/woman consultations.

Appropriate systems ensured flu vaccination programmes were completed and effective treatments and on-going support for those patients identified with the early signs of dementia were available.

A current project being undertaken by the practice aimed to explore what services could be developed and maintained for the elderly population in the area over the next 20 years.

Our findings

The practice offered routine care to older patients. This included, for example, blood tests, blood pressure monitoring and general well man/woman consultations. There was also a 'Health Zone' room within the practice that allowed patients take their own blood pressure, height and weight. We spoke with one patient from this population group who told us the practice staff had shown them how to use some of the machines within the room and that they verbally gave their blood pressure results to their GP.

We saw that the practice had appropriate systems that ensured flu vaccinations were routinely offered to older patients which helped protect them against the virus and associated illness.

We found the practice to be caring in the support it offered to older patients and there were effective treatments and on-going support for those patients identified with early signs of dementia. The practice used a six point cognitive impairment test following any specific reported concerns from relatives, friends or where the patients GP suspected cognitive impairment.

A project was currently being undertaken at the practice following an assessment of the facilities and services for the elderly that are available in Purbeck area of the community. It included an assessment of the services available within the local community hospitals. The aim was to explore what services could be developed and maintained for the next 20 years in the area. Within this project there was an intention to provide more services closer to home and more rehabilitation services in the local community or at home. The aim was to incorporate some hospital admission avoidance and the ability for step-down care when patients left acute 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

Overall, we found the practice provided routine care to patients with long term health conditions.

Flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

We found patients with long term illnesses had their condition and medication reviewed when required.

Research by the practice had established the need for a diabetic outreach service to be created.

Our findings

We saw that flu vaccinations were routinely offered to patients with long term conditions to help protect them against the virus and associated illness.

Patients with long term illnesses had their condition reviewed when required. The practice completed regular medication reviews and patients we spoke with who had been on long term medication told us they felt their condition and medication was reviewed to their satisfaction. This meant that patients with long term conditions were appropriately monitored and medication could be monitored to ensure their wellbeing.

The practice had identified that diabetics who were unable to leave their home were not receiving the same service as patients who could attend the practice in some of the local areas. As a result of this, discussions were being undertaken to establish if a diabetic outreach service could be created. This would ensure these patients needs were reviewed and that the same level of service was provided as at the practice.

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

Overall, we found the practice provided routine care to mothers babies, children and young people.

Expectant mothers attended the practice and were seen for their initial antenatal assessment and then referred to the midwife who held clinics on site.

The practice worked closely with community midwives and health visitors.

Appropriate systems were in place for the identification and referral of safeguarding matters that related to children and young people.

Our findings

Mothers, babies, children and young people received routine care from the practice. Expectant mothers attended the practice and were seen for their initial antenatal assessment and then referred to the midwife who held clinics on site.

The practice worked closely with both the midwives and health visitors within the building and in addition to the clinics held at the practice, childbirth preparation classes were held at the practice.

There was a GP partner who had a lead responsibility for child safeguarding. We saw they had been trained up to the appropriate level (level 3). We saw that appropriate safeguarding policies and referral guidance was available for staff. This ensured they had sufficient information make a child safeguarding referral if required. We saw from patient records that a child identified as at risk had an icon on their electronic patient record screen to advise the clinician of their status. This would ensure that in the event of a child identified as being at risk was seen by different clinicians; this important information would not be lost.

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

Overall, we found the practice provided routine care to the working age population and recently retired patients.

A telephone triage was available for patients at work and flexible appointment times were available throughout the week.

Suitable travel advice was available from the clinical staff within the practice and the supporting information within the waiting areas.

The practice had responded following a completed audit cycle of Accident and Emergency attendances by working patients and increased the opening hours of the practice.

Our findings

The working age population and those recently retired were offered routine care by the practice. The practice offered a telephone triage service daily to provide a service to patients who were at work. This was in addition to patients attending for appointments. The practice opened later three days a week so that the needs were met for patients who could only attend after work.

We saw that flu vaccinations were offered to the working age population and those recently retired to help protect them against the virus and associated illness. The practice also offered travel vaccinations and travel advice. There was appropriate supporting information within the practice for people travelling abroad.

We found the practice to be caring in the support it offered to working age and recently retired patients, and saw were responsive following an audit of attendances by their patients at Accident and Emergency (A&E). The findings were that due to the rural location of the practice, some patients registered at the practice who worked in urban areas found that attending walk-in or A&E departments was more convenient at the end of the working day. To improve this patient outcome, opportunities for flexible appointment times with all of the GP partners in the practice had been increased through later opening.

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

Overall, we found the practice provided routine care to people in vulnerable circumstances.

People within vulnerable communities, for example the travelling community or the homeless were registered at the practice. Primary care was provided when required and liaison was sought with other professionals when required.

Vaccinations were offered when required and an appropriate system for people who may be vulnerable due to their mobility was evident.

Our findings

The practice provided routine care to patients in vulnerable circumstances who may have poor or limited access to primary care. The practice had members of the travelling community registered as patients. The practice provided care to members of this community as and when needed, and also liaised with other professionals such as the community nurse to ensure matters such as child immunisations were completed.

The practice also had patients who were homeless who received care. These patients were registered at the practice address for mailing; however, the practice manager stated that the homeless would frequently relocate which sometimes made continuity of care difficult.

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

We found that the practice was caring about vulnerable patients who were not mobile or able to access the practice with ease. There was information within the practice and available on the practice website about home visits and how one could be arranged.

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

Overall, we found the practice offered routine care to people experiencing a mental health problem.

Routine care appointments for patients experiencing a mental health problem were available and advanced bookings could be made if required.

The practice evidenced they were responsive in making referrals for mental health concerns through patient feedback and records.

Liaison was undertaken with external agencies, for example the mental health crisis team, when required.

Our findings

We saw that the practice offered routine care to patients experiencing a mental health problem. Patients were offered same day pre-booked and follow up appointments were available. If patients wanted to discuss matters in person with their own GP, appointments were available to book up to six weeks in advance.

The practice was responsive in referring patients to other service providers for on-going support. We spoke with one patient who was receiving treatment from a mental health problem. They told us the practice had ensured that information was made available for them for external specialists, for example counselling or support groups.

The practice had a close liaison with the local mental health crisis team and attended multi agency meetings when required to discuss patient concerns.