Corfe Castle Surgery

Quality Report

Toms Mead
Corfe Castle
Wareham
Dorset
BH20 5HH

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Website: www.nhs.uk/corfecastlesurgery

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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?	**Outstanding**
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 Corfe Castle Surgery on 19 July 2017. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice had clearly defined and embedded systems to minimise risks to patient safety. A failsafe process was in place for monitoring blood tests and medical alerts and for managing reviews and screening.
- Staff were aware of current evidence based guidance and adopted these guidelines within clinical templates. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey were consistently higher than local and national averages and showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Information about services and how to complain was available. Improvements were made to the quality of care as a result of complaints and concerns.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. Patients particularly appreciated the daily 'sit and wait' system.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of the requirements of the duty of candour. Examples we reviewed showed the practice complied with these requirements.
- The practice had proactively identified over 4% of the practice population as carers and provided them with the support and guidance needed.
- Staff promoted the friends of Corfe Castle group who provided transport and medicine delivery services to patients in the village.
- The practice worked effectively with members of the community to ensure vulnerable patients were identified and received the care they required. For example, through schools and the local church.
- The GPs worked with staff at the two local community hospitals to access a step down service from secondary care to rehabilitation and for those who need admission to hospital but not necessarily to the district general hospital.
- The practice used an 'Avoidance of Unplanned Admission' (AUA) register. Patients on this registered were assessed and discussed monthly at the multi-disciplinary team meeting.
- The practice, in conjunction with the locality, had developed a virtual ward where at risk patients were discussed on a daily basis within the integrated care team.
- Patients with respiratory disease had access to pulmonary rehabilitation groups and were cared for at the practice by a GP with a specialist interest.
- Patients with diabetes and pre diabetes received proactive, innovative and pioneering approaches to diabetic care. For example; structured education sessions and access tomonitoring devices for continuous monitoring of patients' blood glucose. The practice were beginning to observe patient benefit from this form of monitoring, including reduced blood glucose levels.

We saw one area of outstanding practice:

Patients were truly respected and valued as individuals and are empowered as partners in their care. Feedback from patients, those who are close to them and stakeholders was continually positive about the way staff treat people. Patients said that staff were highly supportive, responsive and go the extra mile and the care they receive exceeds their expectations.

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.

- From the sample of documented examples we reviewed, we found there was an effective system for reporting and recording significant events; lessons were shared to make sure action was taken to improve safety in the practice. When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices to minimise risks to patient safety.
- Staff demonstrated that they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. The practice had fortnightly safeguarding meetings, and more often if required, to review patients on the safeguarding register.
- The practice had adequate arrangements to respond to emergencies and major incidents.

Are services effective?

Good

The practice is rated as good for providing effective services.

- The safe use of innovative and pioneering approaches to care and how it is delivered were actively encouraged. New evidence based techniques and technologies were used to support the delivery of high-quality care. For example, with diabetes care.
- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of current evidence based guidance and had embedded these within templates use on patient records. These had been shared with other practices.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- Staff were consistent in supporting people to live healthier lives through a targeted and proactive approach to health

Summary of findings

promotion and prevention of ill-health, and used every contact with people to do so. For example, patients were offered opportunistic flu vaccines should they be attending the practice for other purposes.

Are services caring?

Outstanding ☆

The practice is rated as outstanding for providing caring services.

- Feedback from patients who use the service, those who are close to them and stakeholders was continually positive about the service and the way staff treat people. Patients told us that staff 'go the extra mile' and the care they receive exceeded their expectations.
- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.
- The practice had proactively identified over 4% of the practice population as carers and provided them with the support and guidance needed.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and 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.

Summary of findings

- Information about how to complain was available and evidence from examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of the requirements of the duty of candour. In examples we reviewed we saw evidence the practice complied with these requirements.
- The lead GP and practice manager encouraged a culture of openness and honesty. The practice had systems for being aware of notifiable safety incidents and sharing the information with staff and ensuring appropriate action was taken.
- The practice proactively sought feedback from staff and patients and we saw examples where feedback had been acted on. The practice engaged with the patient participation group.
- There was a focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The uptake rates for shingles and flu vaccines was higher than CCG averages. For example, the most recent data showed that the practice had achieved 76% vaccination rates for patients over the age of 65 years old compared to the CCG average of 70% and for shingles the practice had achieved the highest rates of shingles vaccines for patients over 75 years in the CCG.
- One of the healthcare assistants was in training to do over 75 year old patient checks.
- The practice worked closely with the fall prevention nurse and balance group to identify patients who might benefit from their support.

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 long-term disease management and patients at risk of hospital admission were identified as a priority.
- Patients with diabetes and pre diabetes received proactive, innovative and pioneering approaches to diabetic care. For

example; structured education sessions and access to pilot monitoring devices for continuous monitoring of patients' blood glucose. The practice were beginning to observe patient benefit from this form of monitoring, including reduced blood glucose levels.

- The practice used an 'Avoidance of Unplanned Admission' (AUA) register. Patients on this registered were assessed and discussed monthly at the multi-disciplinary team meeting. The GPs had access to beds in the local community hospitals to provide 'step up and step down care' which prevented unplanned admissions and transfers to the acute hospitals. Data showed that the practice were the fifth lowest practice out of 93 practices in the CCG for the length of hospital stay.
- The practice, in conjunction with the locality, had developed a virtual ward where at risk patients were discussed on a daily basis within the integrated care team.
- Patients with respiratory disease had access to pulmonary rehabilitation groups and were cared for at the practice by a GP with a specialist interest..
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- End of life care was coordinated with other services involved.
- Atrial Fibrillation checks were offered as a routine during flu clinics.

Families, children and young people

Good

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

- From the sample of documented examples we reviewed we found there were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of accident and emergency (A&E) attendances.
- Immunisation rates were high for all standard childhood immunisations.

Summary of findings

- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives and health visitors to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.
- Staff had access to advice from and worked with the community paediatrician at Swanage Hospital.
- Women could be referred to the local family planning clinic in Wareham to have contraceptive implants and coils fitted.

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 these populations had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care, for example, patients had access to a 'sit and wait' clinic each morning
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

- The practice held a register of patients living in vulnerable circumstances including those with a learning disability. Patients with learning disabilities were seen at any time during the day, and staff adapted the method of working to suit them. There were 14 patients with a learning disability and the GP communicated in detail the preferences, diagnosis and care plans for a selection of these patients.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.

Summary of findings

- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- The GPs worked with and referred patients to local alcohol outreach services.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They 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.
- Pre prepared medicine blister packs were prepared by the dispensary and were available for patients who needed them.
- The practice worked effectively with members of the community to ensure vulnerable patients were identified and received the care they required. For example, through schools and the local church.

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).

- The practice carried out advance care planning for patients living with dementia.
- The practice was a dementia friendly practice and had appropriate signage. There were nominated staff for the coordination of dementia care.
- All patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months. Monthly reports were provided to ensure these reviews took place.
- Reception staff often contacted patients with dementia to remind them of their appointments.
- The practice specifically considered the physical health needs of patients with poor mental health and dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.

Summary of findings

- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published on 7 July 2017. The results showed the practice was performing in line with local and national averages. The results showed the practice was performing better than local and national averages. 211survey forms were distributed and 122 were returned. This represented about 5% of the practice's patient list.

- 98% of patients described the overall experience of this GP practice as good compared with the CCG average of 90% and the national average of 85%.
- 97% of patients described their experience of making an appointment as good compared with the CCG average of 82% and the national average of 73%.
- 97% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 77%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 56 comment cards. These contained detailed comments and named individual staff positively. All were positive about the standard of care received, service provided and staff attitude. Many referred to being appreciative of the practice, commenting that it was the 'best practice around' and feeling 'lucky', 'fortunate' and 'blessed' to being patients at the practice. Comments included positive feedback about the dispensary service, staff and convenience of being able to collect medicines on site. Patients fed back that continuity of service was 'excellent' and that access to appointments was never a problem. Three comment cards had been completed by holiday makers. These were also very positive and praised the prompt care and high standard of treatment.

We spoke with seven patients during the inspection. All seven patients said they were satisfied with the care they received. We spoke with parents who said the service their families had received excellent, second to none, and faultless care. Patients said the staff were all, without exception kind, friendly, compassionate and helpful.

We looked at the friends and family test results from April, May and June 2017. Of the 388 results 379 were wither extremely likely or likely to recommend the practice, one gave a neutral response and three unlikely or extremely unlikely to recommend the practice. Comments all related to the positive remarks. No negative remarks were left.

Outstanding practice

Patients were truly respected and valued as individuals and are empowered as partners in their care. Feedback from patients, those who are close to them and stakeholders was continually positive about the way staff treat people. Patients said that staff were highly supportive, responsive and go the extra mile and the care they receive exceeds their expectations.

Corfe Castle Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP specialist adviser and a CQC pharmacy inspector.

Background to Corfe Castle Surgery

Corfe Castle Surgery is a GP practice which provides a Personal Medical Service contract for approximately 2,484 patients.

The practice is situated in the Dorset village of Corfe Castle and has a dispensary providing a service to approximately 85% of the practice population.

The practice is open Monday, Tuesday, Wednesday and Friday between 8.30am and 6.30pm and from 8.30am until 1pm on Thursdays. Telephone calls are answered between 8am and 8.30. Extended hours include late opening on Monday until 7pm and early morning appointments on Wednesday from 7.15am. Patients have access to a 'sit and wait' clinic each morning, could request telephone appointments or make pre bookable appointments for 8 weeks in advance. Outside of these hours patients are directed to the local NHS out of hours provider via NHS 111. This information is displayed outside of the practice, within the village newsletter and within the patient information leaflet.

The practice registered with CQC in December 2015 and to date data is not yet published however the practice informed us that the majority of patients registered regarded themselves as white British. Deprivation data showed deprivation scores were lower than national averages. Data showed the mix of male and female patients was equal and demonstrated that 30% of patients were over the age of 65 with 10% of patients being over 75 years of age. There was a higher than national prevalence of patients with chronic disease including diabetes, asthma, cancer and palliative care.

The lead GP is also the provider for the practice and has been in post since 2015. He works nine sessions per week. He is supported by a salaried GP (female) who works four sessions per week and a regular locum GP (male) who works two sessions per week. Together the three GPs provide 1.7 whole time equivalent GPs. The team of GPs are supported by three registered nurses and two health care assistants who together provide over 60 hrs of nursing time per week. The clinical team are supported by a practice manager and a team of administration and reception staff.

The practice offered a dispensing services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy. This is led by a dispensary manager and locum dispensary staff whilst permanent staff were being recruited.

The practice is a teaching practice for medical students and had recently been approved as a training practice for doctors training to become GPs. The practice is also a Royal College of GPs (RCGPs) research ready practice and is part of the clinical research network (Wessex).

The practice is registered to provide regulated activities which include:

Treatment of disease, disorder or injury, surgical procedures, maternity and midwifery services and Diagnostic and screening procedures and operate from the main site of:

Toms Mead

Detailed findings

Corfe Castle

Wareham

Dorset

BH20 5HH

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 19 July 2017. During our visit we:

- Spoke with a range of staff including GPs, nurses, practice management staff, dispensary staff and administration staff. We spoke with two members of the patient participation group and a member of the friends of Corfe Castle group who offered transport for patients of the practice. We spoke with seven patients who used the service.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all practice locations
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

Please note that when referring to information throughout this report, for example any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

Good

Are services safe?

Our findings

Safe track record and learning

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents. The practice staff used a clinical commissioning group (CCG) reporting tool for all incidents which was monitored by the CCG governance teams and managed internally at the practice. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Staff said the process of managing significant events was supportive and used a 'no blame culture'. Staff added that there was a contracted expectation to attend practice meetings where these events were discussed and reviewed.
- We looked at the summary of the eight significant events which had occurred in the last two years and sampled two of these records in depth. When things went wrong with care and treatment, patients were informed of the incident as soon as reasonably practicable, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed. The practice carried out a thorough analysis of the significant events.
- We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, an error with a medicine 'blister pack' resulted in a change of procedure which included dispensary staff only setting up these packs in an environment where there were no distractions. (Blister packs are pre prepared daily sealed packs of medicines to assist vulnerable patients). Since this change of process there had not been any further events involving blister packs.
- The practice also monitored trends in significant events and evaluated any action taken.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to minimise risks to patient safety.

- Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. GPs attended safeguarding meetings when possible or provided reports where necessary for other agencies.
- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. Policies, flow charts and contact details were readily available both on the computer system and as paper copies for easy access. The safeguarding policy had last been reviewed in September 2016. GPs were trained to child protection or child safeguarding level three and nursing team to level two. Staff had also received face to face training from the local medical council which staff added had been very informative.
- A failsafe process was in place for monitoring blood tests and medical alerts. A system on the computer was used by the GPs to record when the alert or test result had been read and managed. The practice manager also held a record of medical alert records in paper format for reference. The medicines management lead for the local clinical commissioning group installed any medicine alerts on the prescribing templates used at the practice to ensure safe prescribing.
- Notices in the treatment rooms advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (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).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. Patients told us the practice was always clean. There were cleaning schedules and monitoring systems in place.

Good

Are services safe?

- One of the practice nurses was the infection prevention and control (IPC) clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an IPC protocol and staff had received up to date training. Annual IPC audits were undertaken. The last audit had been completed in April 2017. The lead used the infection control audit tool issued by the local CCG and resulted in a compliance score of 98%. Action included suggestions to introduce a hand washing basin within one of the rooms so it could be used as a consulting room. We saw evidence that action was in progress to address this.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice minimised risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal).

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicines audits, with the support of the local clinical commissioning group pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. A health care assistant was trained to administer vaccines against a patient specific prescription or direction from a prescriber.
- The practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development.
- Dispensary staff showed us standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of regular reviews of these procedures in response to incidents or changes to guidance in addition to an annual review.
- We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. For example, staff explained that they were investigating the use of a barcode scanner to help check the dispensing process.
- Systems were in place to deal with any medicines alerts or recalls, and records kept of any actions taken.
- The dispensary staff were able to offer weekly blister packs for patients who needed this type of support to take their medicines. We saw failsafe systems in place for the process for packing and checking these minimised errors. Staff knew how to identify medicines that were not suitable for these packs and offered alternative adjustments to dispensing where possible.
- Records showed fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature and staff were aware of the procedure to follow in the event of a fridge failure.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. Processes were put in place to ensure all prescriptions for controlled drugs were checked by a second dispenser or GP before being handed out to patients. Controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns with the controlled drugs accountable officer in their area.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date.

We reviewed three personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, qualifications, registration with the appropriate professional body and the appropriate checks through the DBS. The practice worked with volunteer drivers who were either patients at the practice or retired

employees. The GP and practice manager met the volunteers on an annual basis with the Chairman. A risk assessment was in place for these volunteers for the delivery of any medicines.

Monitoring risks to patients

There were procedures for assessing, monitoring and managing risks to patient and staff safety.

- There was a health and safety policy available.
- An environmental risk assessment was completed on 20 December 2016 and had not highlighted any major issues within this new building.
- The practice had an up to date fire risk assessment performed in October 2016 and carried out regular fire drills. The last of which had been completed in March 2017. There were designated fire marshals within the practice. There was a fire evacuation plan which identified how staff could support patients with mobility problems to vacate the premises.
- All electrical and clinical equipment was checked and calibrated to ensure it was safe to use and was in good working order. The latest portable appliance testing (PAT) had been performed in July 2017. The last clinical equipment calibration test had been completed in March 2017.
- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings). The last legionella risk assessment had been performed in March 2017.
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There were processes in place to ensure enough staff were on duty to meet the needs of patients.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. There were additional panic buttons in treatment rooms and reception areas.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- Four comment cards referred to prompt and efficient service being provided in urgent situation. For example, after a fall, a child experiencing breathing difficulties and wounds caused by accidents.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff and for CQC.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs. These guidelines had been included within many chronic disease templates developed and introduced by the practice to ensure evidence based practice was being followed. For example, a diabetic template had been shared with other practice and was being used. The templates contained links to national guidance. For example, the asthma UK website.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). Data provided by the practice showed that the practice had achieved 100% of the total number of points available for 2016/17. There was no comparable data available.

Exception reporting data provided by the practice demonstrated that exception reporting was low. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). For example, there were three patients excepted for asthma indicators. All three patients had recently moved to the practice from elsewhere and not been included in the full data capture.

This practice was not an outlier for any QOF (or other national) clinical targets. Data for July 2017 showed:

- Performance for the total diabetes related indicators showed that the practice had achieved 86 of the 86 points available.
- Performance for mental health related indicators showed that 100% of patients with a mental health diagnosis had a comprehensive care plan in place.

There was a comprehensive care package for patients with diabetes and for patients at risk of developing diabetes:

- All patients with a diagnosis of diabetes were reviewed at least every six months.
- Data showed that approximately 90 patients with detected impaired glucose intolerance (pre diabetes) had been invited to attend five separate appointments with the nurse for education regarding diet and exercise and to monitor body mass index (BMI) and waist measurement. They were then invited to have a repeat blood test at six months. Thirteen of the ninety patients had shown impaired glucose intolerance for more than two years.
- The practice had been chosen as the first practice to pilot the 'liebreview system' (a diabetes management system that gives healthcare professionals and patients reports from glucose monitoring devices) for continuous monitoring of patients' blood glucose. The practice were beginning to observe patient benefit from this such as reduced blood glucose levels.
- Practice staff worked effectively with a diabetic specialist nurse, who visited patients both at the practice and at home. Staff had access to the diabetes clinic at Swanage hospital, and had effective good communication between consultant and nurse specialist via email helping to ensure prompt and current treatment advice for the most needy patients.
- Diabetic eye screening service was offered at Corfe Castle Surgery for patients (and patients from other practices). This means that patients could access the service closer to home.
- Practice staff worked with the diabetic team from Poole hospital to deliver 'RE-FOCUS' a programme designed to support people to manage Type 2 Diabetes. The programme included information and guidance on diet and lifestyle, medicines and treatments, blood glucose monitoring, personal goals and managing relapses.

The practice had developed a prostate practice protocol to monitor all patients with an abnormal prostate blood level. The information was stored on the practice computer system to track whether patients were being cared for in hospital, had been discharged or monitored at the practice. Each patient record had a short summary of targets and parameters. The lead administrator for prostate care had developed a failsafe recall system to ensure patients

Good

Are services effective?

(for example, treatment is effective)

received their blood tests at the right time. The success of this system had led to a similar system being introduced for patients with haematology to ensure they receive appropriate blood tests and treatment.

There was evidence of quality improvement including clinical audit:

- There had been 10 clinical audits commenced in the last two years, two of these were completed audits where the improvements made were implemented and monitored.
- Findings were used by the practice to improve services. For example, recent action taken as a result included a two cycle audit following a data search which indicated that of 29 patients 22 had been referred for appropriate pulmonary rehabilitation. The aim of the audit was to find out why the seven patients had not been referred. Discussions were held with the clinical team and reminders to record where patients had declined rehabilitation were advocated. A repeat of the audit showed an improvement of 42 of 43 patients being referred for rehabilitation.(from 75% to almost 98% in the completed audit cycle)
- Additional audits/batch reporting was performed to ensure screening, reviews, data collection and medicine changes had been carried out.

Of the 56 comment cards, six contained detailed comments of praise about the practice being efficient and for playing an active part in recovery and health promotion. Others commented on prompt referrals and treatment.

Effective staffing

Evidence reviewed showed that staff had the skills and knowledge to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. Staff told us they considered the induction process to be supportive and detailed.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. Nursing staff told us they had experienced difficulties accessing formal asthma diploma training in the area but had kept up to date with current evidence based guidance and had access to the salaried GP who had extensive experience in respiratory medicine.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- Staff told us there was a culture of education and development at the practice. For example, a receptionist was being supported to become a health care assistant and a new practice nurse was being supported to develop her skills. The practice had also supported two apprentices to become permanent members of staff. The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results. All results were scanned and processed by administration staff but seen and acted upon by GPs or nursing staff. The practice manager monitored this system to ensure results were managed promptly.

Good

Are services effective?

(for example, treatment is effective)

- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. Systems were in place to ensure referrals were sent and responded to within timescales.
- Staff use tasks and notifications on the patient record system to enable an audit trail to be maintained of these processes.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. Multi-disciplinary team meetings were held at the practice and practice staff would attend home visits jointly with the community nurses where appropriate to ensure the most effective assessment and treatment was provided.

Staff worked with other health care professionals when patients moved between services. A system was in place to ensure all patients who had been discharged from hospital were contacted by the GP within three days.

Information was shared between services, with patients' consent, using a shared care record. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice used an 'Avoidance of Unplanned Admission' (AUA) register. Patients on this registered were assessed and discussed monthly at the multi-disciplinary team meeting. The practice, in conjunction with the locality, had developed a virtual ward where at risk patients were discussed on a daily basis within the integrated care team. The GPs had access to beds in the local community hospitals to provide 'step up and step down care' which prevented unplanned admissions and transfers to the acute hospitals. Data showed that the practice were the fifth lowest practice out of 93 practices in the CCG for the length of hospital stay.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances. The GPs and nursing team worked with palliative care teams in the area. The lead GP often gave his mobile number to patients at the end of their life to ensure they received continuity of care in a timely way.

The GPs 'collect' patients from the waiting room to make patients feel welcome but also to take the time to observe the patient and start the consultation immediately often providing valuable observation of the patients mobility, demeanour and body language.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was obtained using structured templates and free text on patient record system.
- The GP and nurse had provided double appointments where immunisations or blood tests were required for patients with a learning disability. The GP had held the hand of a patient to stop the procedure if the patient had demonstrated any body language indicating the patient was not happy for the procedure to continue.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol. One of the comment cards was appreciative about the smoking cessation support and thanked the practice nursing team for supporting a patient to give up smoking after 55 years.

The practice's uptake for the cervical screening programme was 85%, which had met the CCG target of 80% and was higher than the national average of 81%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged

Good

Are services effective?

(for example, treatment is effective)

uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisations were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable to CCG/national averages. For example, rates for the vaccines given to under two year olds and five year olds were 100% with no patients declining immunisations.

The practice staff offered vaccines during other appointments or outside of appointment times. For example, where a relative was at the practice with a family member they were offered a vaccine there and then. The most recent data showed that the practice had achieved 76% vaccination rates for patients over the age of 65 years old compared to the CCG average of 70% and for shingles the practice had achieved the highest rates of shingles vaccines for patients over 75 years in the CCG.

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

We saw correspondence regarding the Dorset bowel cancer screening programme for 2015. This letter showed that results in the practice for bowel screening were 66% compared with the CCG average of 61%.

Outstanding ☆

Are services caring?

Our findings

Feedback from patients who use the service, those who are close to them and stakeholders was continually positive about the service and the way staff treated people. Patients told us that staff go the extra mile and the care they receive exceeds their expectations.

Kindness, dignity, respect and compassion

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same sex.

We were informed of many examples where patients considered that staff had gone 'above and beyond'. These included:

- Administration staff contacting patients to guide them through the hospital referral process
- Palliative care patients receiving the mobile telephone number of the GP so they could attend to any issues promptly before out of hours providers and palliative care teams attended.
- Staff worked flexibly to ensure patients received the care they needed. For example, fitting patients into appointments or adding them to the ends of clinics where patients had forgotten to attend appointments.
- Dispensary staff delivering medicines in the village.
- Seeing patients on a daily basis until psychological therapies become available
- Staff attending the funerals of patients.

All of the 56 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comments often referred to staff being expressing genuine concern about patients and of the efficient and friendly service. Five of the cards referred to being treated as a human being rather than just a patient or a number.

We spoke with seven patients and two members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was significantly above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 99% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 91% and the national average of 89%.
- 98% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 86%.
- 99% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%
- 98% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 86%.
- 100% of patients said the nurse was good at listening to them compared with the clinical commissioning group (CCG) average of 94% and the national average of 91%.
- 98% of patients said the nurse gave them enough time compared with the CCG average of 94% and the national average of 92%.
- 100% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average of 98% and the national average of 97%.
- 97% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 99% of patients said they found the receptionists at the practice helpful compared with the CCG average of 90% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings.

Outstanding ☆

Are services caring?

Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Children and young people were treated in an age-appropriate way and recognised as individuals.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 99% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average of 90% and the national average of 86%.
- 97% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 97% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 92% and the national average of 90%.
- 98% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%)

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.)
- The practice identified military veterans in line with the Armed Forces Covenant 2014. This enabled priority access to secondary care to be provided to those patients with conditions arising from their service to their country.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website and within the patient newsletter. Support for isolated or house-bound patients included signposting to relevant support and volunteer services. Practice staff had supported and referred patients to the 'Friends of Corfe Castle' group. This provided patients with transport to and from the practice and hospital and provided a prescription delivery service.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 109 patients as carers (4.4% of the practice list). The practice had appointed a member of staff as the lead for carers to help ensure that the various services supporting carers were coordinated and effective. Information was provided within the patients' newsletter about how patients could access support. Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. Monthly reports were produced to highlight carers on the register to ensure they were offered an annual carers health check.

The practice held carers tea parties where carers could meet and receive support from other carers and access any support and information they needed.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. We were told that the GP would often attend the funerals of patients in the village. Surviving family members were provided with support and advice on how to find a support service and counselling services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered extended hours on Mondays until 7pm and early morning appointments on Wednesdays from 7.15am. Patients had access to a 'sit and wait' clinic each morning. There were longer appointments available for patients who needed them.
- Opening times, contact details and out of hours details were advertised within the parish newsletter.
- Home visits were available for patients who had clinical needs which resulted in difficulty attending the practice. These were carried out by both GPs and the practice nursing team. We were given examples of where visits by both GP and nurse had resulted in reassurance for the patient, their family and the prevention of a hospital admission.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Health visitors and midwives saw patients at the practice every two weeks.
- Abdominal Aortic Aneurysm screening was offered monthly at the practice.
- Diabetic eye screening service was offered fortnightly at the practice.
- The GP offered health checks for RNLI (Royal National Lifeboat Institution) crew members free of charge.
- The GP provided a cryotherapy clinic for the treatment of superficial skin lesions and offered steroid injections for joint pain.
- The practice had responded to the locality 'Purbeck pledge'. The aim was to encourage a healthier lifestyle in the community. The practice staff liaised with local schools and this year members of the group, including staff at the practice were introducing the daily mile for schools where children were encouraged to walk at least a mile each day. The aim of the Daily Mile is to improve the physical, emotional and social health and wellbeing of children,regardless of age or personal circumstances.
- Same day appointments were available for patients using the sit and wait service. Patients told us they were usually able to see their usual GP with these appointments.
- Patients could access combined appointments to see the practice nurse and GP at the same time.
- The practice sent text message reminders of appointments.
- Patients could access online prescription requests, booking of appointments and request access to clinical records.
- The practice used a text messaging reminder service for patients the day before
- Patients were able to receive travel vaccines available on the NHS and were referred to other clinics for vaccines available privately.
- There were accessible facilities, which included a hearing loop, interpretation services and braille information available on the front door. Comment cards referred to staff being aware of disabilities and responding is a sensitive manner.
- Disabled parking spaces, level access and automatic opening doors were available. Accessible toilet facilities, dementia friendly signage and clocks were provided.
- A designated child's play area and age appropriate toys were available.
- The practice had a monthly column in the local newsletter where health information or practice changes were communicated.

The lead GP told us he considered the patients journey often began before they were seen at the practice. This response was possible following communication with members of the community or through observation of the patient within the village environment. Staff were able to communicate their own observations or those of members of the community to the GPs informally using the open door approach adopted by the GPs or by using a 'practice huddle'. This was a notice board situated in the staff area where staff could relay non urgent information or informal observations about patients.

Access to the service

The practice was open Monday, Tuesday, Wednesday and Friday between 8.30am and 6.30pm and from 8.30am until 1pm on Thursdays. Telephone calls are answered between 8am and 8.30. Extended hours included late opening on Monday until 7pm and early morning appointments on

Good

Are services responsive to people's needs?

(for example, to feedback?)

Wednesday from 7.15am. Patients had access to a 'sit and wait' clinic each morning, could request telephone appointments or make pre bookable appointments up to eight weeks in advance. Outside of these hours patients were directed to the local NHS out of hours provider (via NHS 111). This information is displayed outside of the practice, within the village newsletter and within the patient information leaflet.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment were consistently significantly higher than local and national averages.

- 96% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 80% and the national average of 76%.
- 100% of patients said they could get through easily to the practice by phone compared to the national average of 71%.
- 98% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 90% and the national average of 84%.
- 96% of patients said their last appointment was convenient compared with the CCG average of 88% and the national average of 81%.
- 97% of patients described their experience of making an appointment as good compared with the CCG average of 82% and the national average of 73%.
- 83% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 62% and the national average of 58%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.
- Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had a system for handling complaints and concerns.

- Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- The practice manager 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. This included information within the patient newsletter and posters within the waiting areas.

We looked at two complaints received in the last 12 months and found these had been satisfactorily handled, dealt with in a timely way, with openness and transparency. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care. For example, a complaint about a communication error had led to an apology to the patient and discussion in the next practice meeting about double checking telephone details.

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 had a mission statement which read 'Delivering high quality patient care through teamwork, professionalism, commitment and empathy, in a safe and open environment'. Staff knew and understood the values.
- The practice had a clear strategy and supporting business plans which reflected the vision and values and were regularly monitored. For example, the last business plan included a plan for a GP to become a GP trainer. This had been achieved with the first foundation 2 doctor starting at the practice in the next few months.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas. For example, medicines management, safeguarding lead, significant event and risk assessor, infection control lead, carers lead and a dementia friendly advisor.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. Clinical templates and reporting structures had been developed at the practice to ensure patients received the right treatment.
- There were appropriate arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.
- We saw evidence from minutes of a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

Leadership and culture

On the day of inspection the leadGP at the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the GPs and practice management were approachable and always took the time to listen to all members of staff. Staff said there was effective team at the practice with all staff members being treated equally and a sense of mutual respect shared.

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

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure and staff felt supported by the lead GP and practice management.

- The practice held and minuted a range of multi-disciplinary meetings including meetings with district nurses and social workers to monitor vulnerable patients. Effective joint working was in place. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held regularly. Staff said the team attended BBQs parties and more formal team events. Minutes from meetings were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the lead GP and practice manager in the practice. All staff were involved in discussions about

Are services well-led?

Good

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

how to run and develop the practice, and were encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients and staff. It proactively sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG consisted of 9 members who met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, suggestions to simplify the patient questionnaire and improve signage in the waiting room had been made. Patients were not expected to be on the PPG to offer feedback. For example, one patient had suggested name badges for staff would be useful. This was acted upon and now staff all wear name badges.
- the NHS Friends and Family test, complaints and compliments received.
- staff through generally feedback, staff meetings and appraisals. Staff told us the practice manager and GPs were very approachable and added 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 to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, the practice staff had developed clinical templates to ensure staff were prompted to complete evidence based care. The practice manager had organised a practice nurse meeting within the locality (six practices) and gave training on how to produce and use the templates. Feedback from these sessions were positive.

The practice was a Royal College of GPs (RCGPs) research ready practice and was part of the clinical research network (Wessex). Patients were invited to attend these trials.

The practice was a member of a local federation to share innovation and ideas.