Bute House Surgery

Quality Report

Grove Medical Centre
Wootton Grove
Sherborne
Dorset
DT9 4DL
Tel: 01935 810 900
Website: www.butehousesurgery.co.uk

Date of inspection visit: 26 May 2016
Date of publication: 25/07/2016

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Bute House Surgery on 26 May 2016. 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 an effective system in place for reporting and recording significant events.
- Risks to patients were assessed and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had the skills, knowledge and experience to deliver effective care and treatment.
- The practice had safe and effective systems for the management and dispensing of medicines, which kept patients safe.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was aware of and complied with the requirements of the Duty of Candour.

We saw areas of outstanding practice:

- As part of an over 75s initiative piloted at the practice, the practice employed two community health care assistants, who bridged the gap between clinical and social care. Older patients were identified in various ways from clinicians, reception staff, frailty measures and outside agencies who may be at risk of hospital

Summary of findings

admission. These patients were comprehensively assessed in their own homes for their social, physical and mental well-being. They were offered an over 75s health check and then their care was discussed at multi-disciplinary meetings to ensure appropriate services were provided.

- Patients' emotional needs were seen as important as their physical needs. The practice could demonstrate caring and empathy toward patients in time of loss and bereavement. Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. On the anniversary of the loss of the family member the practice sent a 'thinking of you' card to family members to express further sympathy and offer on-going support.
- Patient satisfaction with overall care received at the practice, quality of consultations at the practice and satisfaction with accessing primary care were the highest of all GP practices within the locality clinical commission group (CCG). Patient satisfactions within the CCG were above the national averages. Patients thought Bute House Surgery staff provided high quality compassionate care.
- The practice held daily weekday surgeries at Sherborne Girls School (a boarding independent school) to meet the particular challenges of teenage girls living away from home. The practice had engaged with teenage patients at the girls' school through a cycle of three yearly surveys to capture the views of the cohort of youngsters regarding services and facilities. This led to reviewing the frequency of drop in sessions at the school.

The area where the provider should make improvements is:

- Review the monitoring of vaccine refrigerator temperatures.

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.

- There was an effective system in place for reporting and recording significant events.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and 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 in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average for the locality and compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with multidisciplinary teams to understand and meet the range and complexity of patients' needs.

Are services caring?

Outstanding

The practice is rated as outstanding for providing caring services.

- Data from the National GP Patient Survey showed patients rated the practice higher than others for all aspects of care. For example, with satisfaction of the overall care received, the quality of consultations at the practice and satisfaction with accessing primary care.
- We observed a strong patient-centred culture. For example, GPs told us that palliative care patients had their personal home telephone contact numbers, should they need additional support outside of practice hours.

Summary of findings

- Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. For example, the practice believed that care was at risk of becoming fragmented through the multiple initiatives and multiple registers of patients at risk. They had brought together patient registers for end of life, avoiding unplanned admissions, frail and also any patient identified by the GPs or nurses to form a single supportive care register. This formed the basis for discussion at multi-disciplinary team meetings.
- Views of external stakeholders were very positive and aligned with our findings.

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Feedback from patients was continually positive about the way staff treated them. They thought that the staff 'went the extra mile' and the care they received exceeded their expectations.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.
- When families suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. On the anniversary of the loss of the family member the practice sent a 'thinking of you' card to family members to express further sympathy and offer on-going support.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group to secure improvements to services where these were identified. For example: The practice offered appointments until 7pm Mondays to Thursdays evenings for working patients who could not attend during normal opening hours.
- There were long appointments and home visits available for patients with a learning disability.
- Home visits were available for older patients and patients who had difficulty attending the practice.
- All patients were able to request longer appointments.

Summary of findings

- Home visits were triaged with a follow up telephone call to the patients to ensure urgent visits were scheduled for a morning visit.
- Patients could email, text or phone the practice for clinical advice.
- The practice held daily weekday surgeries at Sherborne Girls School (a boarding independent school) to meet the particular challenges of teenage girls living away from home.
- Patients 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.
- Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice used the 'yellow health book' designed to aid communication for patients with a learning disability. The book's intention was to enable patients to better look after their own health and was produced in an easy to read format. Topics covered included an individual's eating habits, best methods of communication, family history and immunisation records.
- The practice funded community health care assistants (HCAs) visited vulnerable patients of concern in their homes, for example if a GP or nurse was unable to make contact on the telephone then the HCA conducted a home visit to check all was well.

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 this.
- There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings.
- There was an overarching governance framework which supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.

Summary of findings

- The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice sought feedback from staff and patients, which it acted on. The large patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people.

The predominant patient group for the practice population was for those over 65. This was significantly above the national average; for example 15% of the practice list were aged between 75 – 85 years, compared with the national average of 8%.

- The practice offered personalised care to meet the needs of the older people 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 believed that care was at risk of becoming fragmented through the multiple initiatives and multiple registers of patients at risk. They had brought together patient registers for end of life, avoiding unplanned admissions, frail and also any patient identified by the GPs or nurses to form a single supportive care register. This formed the basis for discussion at multi-disciplinary team meetings.
- As part of an over 75s initiative set up by one of the GPs at the practice, the practice employed two community health care assistants, who bridged the gap between clinical and social care. Older people at risk of hospital admission were identified in various ways from clinicians, reception staff, frailty measures and outside agencies. These patients were comprehensively assessed in their own homes for their social, physical and mental well-being. They were offered an over 75s health check and then their care was discussed at multi-disciplinary meetings to ensure appropriate services were provided.
- Patients residing in nursing and care homes received routine regular visits by a GP, allowing early identification of illness and health decline. The practice believed this had improved relationships with the homes and staff and reduced unnecessary unplanned admissions to hospital.
- Patients received a birthday card from the practice on their 90th and 100th birthday.
- The practice had established links with the community matron and the partnership for older people (POPP) 'Wayfinders', a voluntary organisation that signposted patients to appropriate services, such as advice for homecare and pension advice.

Summary of findings

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Diabetes indicators for the monitoring of patients with this condition were in line with local and national averages, with low exception rate reporting. (This is when patients are excluded from the statistics, for example, due to failure to attend for a review or extreme frailty.)
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and 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.
- Practice nurses were qualified and specialised with diplomas in the management of diabetes, asthma, and chronic obstructive pulmonary disease (COPD).
- Patients were provided with condition-appropriate care plans.
- All patients were encouraged to self-manage their condition and those needing support had access to 'My Health My Way', a local health coach service.

Families, children and young people

Good

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

- There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- The percentage of patients with asthma who had a review of their condition and advice on control their condition was 83%. This was slightly higher than the local CCG average of 78% and national average of 75%.
- Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The percentage of women who were invited for and attended a cervical screening test was 82%, which was in line with local and national averages.
- The premises were suitable for children and babies.

Summary of findings

- We saw positive examples of joint working with midwives, health visitors and school nurses.
- The health visiting team were co-located in the practice and met with the practice team frequently. Health visitors were on the same clinical records system and shared comprehensive patient records.
- The practice policy was to see children on the same day, to avoid unnecessary A&E attendances.
- Appointments were available outside school hours and children's clinics such as flu immunisation were scheduled for school holidays.
- The practice liaised with local schools, for example with regard to challenging students, particularly with regard to attendance where health concerns may be an influencing factor.
- The practice held daily weekday surgeries at Sherborne Girls School (a boarding independent school) to meet the particular challenges of teenage girls living away from home.
- The practice had engaged with teenage patients at the girls' school through a cycle of three yearly surveys to capture the views of the cohort of youngsters regarding services and facilities. This led to reviewing the frequency of drop in sessions at the school.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students).

- The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.
- There were extended hours clinics which ran from Monday through to Thursdays until after 7pm.
- Flu clinics were held on a weekend.
- The practice offered telephone consultations, as well as an opportunity to email the practice.

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.

Summary of findings

- The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability. For example, the practice said they had one transient patient who registered the practice address as their permanent address for the receiving of post.
- There were long appointments and home visits available for patients with a learning disability.
- The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations, such as The Rendezvous for young people and community alcohol and drug advisory services (CADAS) for addiction issues.
- Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.
- One of the GPs was chair of the Sherborne Voluntary Ambulance. This service provided transport and social outings to vulnerable local residents, including patients registered with the practice.
- The practice had a carer's lead who helped carers to access help and support from various agencies.
- The practice had a higher than average population of patients with severe learning disability. These patients received comprehensive annual health checks and were seen regularly to build a good relationship with patients and carers to identify early onset of illness.
- The practice used the 'yellow health book' designed to aid communication for patients with a learning disability. The book's intention was to enable patients to better look after their own health and was produced in an easy to read format. Topics covered included an individual's eating habits, best methods of communication, family history and immunisation records.
- The practice worked with Age UK to identify the support patients need to enable safe and independent living (SAIL).
- The practice funded community health care assistants (HCAs) visited vulnerable patients of concern in their homes, for example if a GP or nurse was unable to make contact on the telephone then the HCA conducted a home visit to check all was well.

Summary of findings

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).

- 86% of patients diagnosed with dementia that had had their care reviewed in a face to face meeting in the last 12 months, which is comparable to the local CCG average of 85% and the national average of 84%.
- The percentage of patients with mental health needs who had been seen in the preceding 12 months and had an agreed, comprehensive care plan was comparable with local CCG and national averages.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia. For example, staff were Dementia Friends and had completed the training from the Alzheimer's Society.
- The practice provided facilities for Improving Access to Psychological Therapies workers (IAPT) and child and adolescent mental health services (CAMHS) to consult patients in a convenient and familiar environment.
- The Citizen's Advice Bureau provided fortnightly sessions within the practice specifically for people with mental health issues.
- The practice had a dementia and vulnerable adults lead, member of staff who co-ordinated regular multi-disciplinary team meetings at the practice to discuss the care needs of such patients.

Summary of findings

What people who use the service say

The most recent national GP patient survey results were published in January 2016. The results showed the practice was above both local and national averages. 234 survey forms were distributed and 125 were returned. This represented about 2.1% of the practice's patient list.

- 93% of patients found it easy to get through to this surgery by phone compared to a Clinical Commissioning Group average of 85% and a national average of 73%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried (CCG average 84% and national average 76%).
- 98% of patients described the overall experience of their GP surgery as good (CCG average 90% and national average 85%).
- 98% of patients said they would recommend their GP surgery to someone who has just moved to the local area (CCG average 85% and national average 79%).

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 21 comment cards which were all positive about the standard of care received. In addition over 120 patients contacted us electronically to leave comments about the practice. Patients told us that the staff were compassionate, committed to providing high quality care and responsive to needs.

We spoke with four patients during the inspection. All said they were happy with the care they received and thought staff were approachable, committed and caring.

The practice published results from Friends and Family test surveys on their website and in the practice newsletters. The most recent results from March 2016 indicated that from 20 respondents, 85% would recommend the practice (14 extremely likely and three likely, with three where the question was not answered).

We looked at comments patients had made about the practice on the NHS Choices website. There was one comment left in the last 12 months. This feedback was highly complementary.

We received comments from four local care homes where patients were registered at the practice. Comments were positive and one home manager said that the practice had a personal touch in being responsive and caring toward patients.

Areas for improvement

Action the service SHOULD take to improve

The area where the provider should make improvements is:

- Review the monitoring of vaccine refrigerator temperatures.

Outstanding practice

We saw areas of outstanding practice:

- As part of an over 75s initiative piloted at the practice, the practice employed two community health care assistants, who bridged the gap between clinical and social care. Older patients were identified in various ways from clinicians, reception staff, frailty measures and outside agencies who may be at risk of hospital admission. These patients were comprehensively assessed in their own homes for their social, physical and mental well-being. They were offered an over 75s health check and then their care was discussed at multi-disciplinary meetings to ensure appropriate services were provided.
- Patients' emotional needs were seen as important as their physical needs. The practice could demonstrate caring and empathy toward patients in time of loss

and bereavement. Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. On the anniversary of the loss of the family member the practice sent a 'thinking of you' card to family members to express further sympathy and offer on-going support.

- Patient satisfaction with overall care received at the practice, quality of consultations at the practice and satisfaction with accessing primary care were the highest of all GP practices within the locality clinical commission group (CCG). Patient satisfactions within the CCG were above the national averages. Patients thought Bute House Surgery staff provided high quality compassionate care.
- The practice held daily weekday surgeries at Sherborne Girls School (a boarding independent school) to meet the particular challenges of teenage girls living away from home. The practice had engaged with teenage patients at the girls' school through a cycle of three yearly surveys to capture the views of the cohort of youngsters regarding services and facilities. This led to reviewing the frequency of drop in sessions at the school.

Bute House 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 Bute House Surgery

Bute House Surgery is situated in the market town of Sherborne, Dorset. Sherborne is close to the Somerset border and approximately 10% of the patients came from Somerset. This meant the practice liaised with community health teams and secondary care services across the two counties. There were approximately 5850 patients registered at the practice. The practice list contained a higher than average elderly and teenage population and a higher than average population with long term conditions. The patients list was a diverse socio-economic group, including pockets of deprivation and a rural population with poor local transport.

The practice was purpose built and shares the site with another separately registered GP practice. There is parking at the practice and ground floor consulting rooms.

There are four GP partners (two female and two male), three nurses and three health care assistants. There is a practice manager and deputy practice manager. One of the GPs worked part-time. As a dispensing practice there is a dispensary manager and two additional dispensary staff. The team is supported by receptionists and administrators.

The practice is a teaching practice for medical students.

The practice is open between 8am and 6.30pm Monday to Friday. On four evenings a week (Monday to Thursday) bookable appointments are available until 7pm. GP patient consultations start at 8.30am except on Wednesdays, when this is from 9am. Nurse consultations start at 8.30pm every morning except Thursday when they start at 8am.

When the practice is closed patients are directed to the Dorset Emergency Care Service, accessed via the national NHS 111 telephone service for health advice.

We previously inspected the practice on 21 January 2014 and found the practice was meeting all the standards that we inspected. We have re-inspected the practice under our new inspection regime and to award a rating to the practice.

All regulated activities are carried out from the following location:

Bute House Surgery

Grove Medical Centre

Wootton Grove

Sherborne

Dorset

DT9 4DL

Bute House Surgery holds a personal medical services contract with NHS Dorset Clinical Commissioning Group (CCG).

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 26 May 2016. During our visit we:

- Spoke with a range of staff (four GPs, two nurses and two health care assistants, the practice manager and deputy practice manager, dispensary manager and two dispensers and reception/administrators) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised 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.

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 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 an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports national patient safety alerts and minutes of meetings where these were discussed. Alerts were received electronically, disseminated to all staff electronically, logged in an alert book and any action taken was signed as actioned. GPs reported a recent example of NICE advice that had been implemented at the practice in relation to antibiotic dosing guidance for Amoxicillin medicine.

When there were unintended or unexpected safety incidents, patients received reasonable support, truthful information, a verbal and written apology and were told about any actions to improve processes to prevent the same thing happening again. For example, a significant event was recorded after a breathless patient saw three GPs on three occasions and there was a delayed diagnosis of heart failure. As a result the practice staff discussed the incident and developed an improved pathway for actioning test results through the use of a single page/flow chart and prompts for reviewing clinical symptoms and test results with in-built peer review. As a result of this change in process no further incidents of this type had occurred.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse that reflected relevant legislation and local requirements and 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. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training relevant to their role. GPs were trained to the recommended child safeguarding level three.
- A notice in the waiting room 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 check (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. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. The most recent infection control audit took place on 19 May 2016. The audit made nine recommendations. We saw records to demonstrate that all recommendations had been implemented. For example, updating staff policies on return to work following diarrhoea or vomiting to 48 hours after the symptoms ceased and completing a risk assessment regarding the disposal of liquid waste down designated 'dirty' sinks.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Staff showed us that one of the vaccine refrigerators had been recording slightly above the recommended temperatures whenever the door was opened, however this was being addressed by the practice. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and systems were put in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer

medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.

- 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. Any medicines incidents or 'near misses' were recorded for learning and the practice had a system in place to monitor the quality of the dispensing process. Dispensary staff showed us standard operating procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines).
- 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. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed four personnel files and found appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- There were failsafe systems in place 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had an up to date fire risk assessment (reviewed and revised in April 2016) and carried regular fire drills in coordination with the GP practice that shared the premises. The most recent fire drill was carried out in March 2016. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly.
- The practice had a variety of other risk assessments in place 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). A check for legionella risk was carried out on a monthly basis. We reviewed records, which confirmed this took place.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. The practice had responded to the growing patient list by offering additional GP patient appointments.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place 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.
- 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 fit for use.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place 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.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

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). The most recent published results were 96.3% of the total number of points available, with exception reporting either comparable to or below CCG and national averages. (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). This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/2015 showed:

- Performance for diabetes related indicators was similar to the Clinical Commissioning Group (CCG) and national average. One indicator was better than local averages; those patients with diabetes who had received a foot examination and risk classification following the examination were 97%. The CCG average was 91% and the national average was 88%. The practice benefitted from a diabetes nurse specialist who worked in partnership with the practice nurses in a monthly clinic session.
- Performance for mental health related indicators similar to the CCG and national average for example, the percentage of patients with mental health needs who had been seen in the preceding 12 months and had an agreed, comprehensive care plan was 91%, comparable with local CCG average of 92% and national average of 88%.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the CCG and national average at 81%, compared to the local average of 85% and national average of 84%.
- The practice used QOF outcomes to review their clinical diagnosis and recording systems. For example the QOF scores had indicated that the practice had a high exception reporting rate for osteoporosis (brittle and fragile bones) diagnoses. As a result the practice coding for patients diagnosed with osteoporosis was reviewed and the practice concluded that there had been over diagnosis of the condition and a revised coding framework was introduced.

Clinical audits demonstrated quality improvement.

- The practice sent us examples of 17 non-clinical audits and three full cycle clinical audits completed in the two years. Monitoring of repeat of clinical audits, such as for antibiotic prescribing, minor surgery and anti-coagulation therapy (medicines to prevent blood clotting) showed improvements were made.
- The practice participated in local audits, such as medicines management and participated in research by identifying patients suitable to be nominated and potentially contacted for consent to be part of clinical studies.

Information about patients' outcomes was used to make improvements. For example, the practice carried out patient targeted clinical feedback surveys for contraceptive implant fittings, intrauterine contraceptive devices (IUCDs) and minor surgery. Feedback was used to improve services, such as length and convenience of appointment and information about services.

Effective staffing

Staff had the skills, knowledge and experience 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.

Good

Are services effective?

(for example, treatment is effective)

- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those staff reviewing patients with long-term conditions
- Staff administering vaccinations and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccinations 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.
- 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 during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. 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. Information such as NHS patient information leaflets were also available.
- The practice shared relevant information with other services in a timely way, for example, when referring patients to other services.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated.

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.
- Feedback from four local nursing and care homes with patients registered at the practice was that the GPs supported patients with making important decisions about their care and treatment by assisting with assessments of their mental capacity. We were told the GPs took the lead in liaising with community based professionals to support patients to understand their choice options.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support.

- These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients were then signposted to the relevant service.
- The practice had established links with the community matron and the partnership for older people (POPP) 'Wayfinders', a voluntary organisation that signposted patients to appropriate services, such as advice for homecare and pension advice.
- All patients with a long-term condition were encouraged to self-manage their condition and those needing support had access to 'My Health My Way', a local health

Good

Are services effective?

(for example, treatment is effective)

coach service. (My Health My Way is a support service tohelp patients develop the confidence, knowledge and skillsto tackle symptoms such as immobility, breathlessness,anxiety or daily pain).

- The practice funded two community health care assistants (HCAs) who visited vulnerable patients of concern in their homes, for example if a GP or nurse was unable to make contact on the telephone then the HCA conducted a home visit to check all was well. We heard from practice staff of examples assessing additional support services and risk, such as assessing falls risks in patients' homes from loose rugs and checking patients' medications at home were in date. Both of the HCAs who visited the patients had worked at the local hospital and had maintained close links with the community rehabilitation teams based at the hospital for additional support referrals.

The practice's uptake for the cervical screening programme was 82%, which was comparable to the CCG average of 84% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged 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 screening.

Childhood immunisation rates for the vaccinations given were comparable to CCG/national averages. For example, childhood immunisation rates for the vaccinations given to two year olds ranged from 96% to 100% and five year olds from 95% to 100%. This was slightly above the CCG ranges of between 94% to 97% and 92% to 97%.

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.

Outstanding ☆

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed 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.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- The practice held a register of patients living in vulnerable circumstances including homeless patients. The practice said they had one transient patient who registered the practice address as their permanent address for the receiving of post. This meant they were able to engage more effectively with society as they could be contacted via the practice.
- One of the GPs was chair of the Sherborne Voluntary Ambulance. This service provided transport and social outings to vulnerable local residents, including patients registered with the practice.

Patients were respected and valued as individuals and were empowered as partners in their care. Feedback from patients was continually positive about the way staff treated them. They thought that the staff 'went the extra mile' and the care they received exceeded their expectations. All of the 21 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. The practice ran a virtual on-line patient participation group (PPG) with over 1,100 members. We received on-line feedback from approximately 125 members of the PPG. They told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Patients who uses services were active partners in their care. Staff were fully committed to working in partnership with patients and made this a reality for each person. Staff always empowered patients who used the service to have a voice. Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. The practice came highest overall for all the GP practices in the CCG locality, indicating outstanding levels of patient satisfaction with how caring the practice staff were. For example:

- 98% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 92% and national average of 89%.
- 96% of patients said the GP gave them enough time (CCG average 90% and national average 87%).
- 99% of patients said they had confidence and trust in the last GP they saw (CCG average 97% and national average 95%).
- 97% of patients said the last GP they spoke to was good at treating them with care and concern (CCG average 89% and national average 85%).
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern (CCG average 92% and national average 91%).
- 93% of patients said they found the receptionists at the practice helpful (CCG average 90% and national average 87%).

The practice had a 'you say, we did' information board in the patient waiting room. This showed how the practice responded to patient feedback. For example, in response to patient feedback, the practice provided information about how patients could speak with a GP when they felt that they did not need to come into the practice. There was information about why a GP could run late and what else GPs did when they were not seeing patients. The board responded to queries why there was music played in the patient waiting room (to help mask confidential conversations of patients at the reception desk) and a response to comments made regarding the choice of magazines available in the patient waiting room.

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

Are services caring?

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 on the comment cards we received was also positive and aligned with these views.

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 above local and national averages. For example:

- 95% of patients said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 89% and national average of 86%.
- 92% said the last GP they saw was good at involving them in decisions about their care (CCG average 86% and national average 82%)
- 95% said the last nurse they saw was good at involving them in decisions about their care (CCG average 88% and national average 85%)

Staff told us that translation 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.

Patient and carer support to cope emotionally with care and treatment

Notices in the patient waiting room told patients how to access a number of support groups and organisations.

The practice's computer system alerted GPs if a patient was also a carer, this including young carers who had a role in caring for a parent or relative. The practice had identified 2.8% of the practice list as carers. The practice employed a carer's lead, who worked with carers to provide health checks and to signpost carers to support organisations. Written information was available to direct carers to the various avenues of support available to them.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. On the anniversary of the loss of the family member the practice sent a 'thinking of you' card to family members to express further sympathy and offer on-going support.

GPs told us that palliative care patients had their personal home telephone contact numbers, should they need additional support outside of practice hours.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example:

- The practice offered appointments until 7pm Mondays to Thursdays evenings for working patients who could not attend during normal opening hours.
- There were long appointments and home visits available for patients with a learning disability.
- All patients are able to request longer appointments.
- Home visits were available for older patients and patients who had difficulty attending the practice.
- Home visits were triaged with a follow up telephone call to the patients to ensure urgent visits were scheduled for a morning visit.
- Patients could email, text or phone the practice for clinical advice.
- Same day appointments were available for children and those with serious medical conditions.
- Patients were able to receive travel vaccinations available on the NHS or privately.
- There were disabled facilities and translation services available.
- The practice used the 'yellow health book' designed to aid communication for patients with a learning disability. The book's intention was to enable patients to better look after their own health and was produced in an easy to read format. It enabled patients with learning disabilities to keep an accurate record of their health, at the same time providing comprehensive information for their carer or other health professional. Topics covered included an individual's eating habits, best methods of communication, family history and immunisation records.
- Young females under the age of 19 made up 1% of the practice population and 67% of the teenage population were students at a local independent girl's boarding school. The practice GPs maintained positive links with this group through a morning clinic at the school each weekday (and occasional weekend visits on request).
- The practice had engaged with teenage patients at the girls' school through a cycle of three yearly surveys to capture the views of the cohort of youngsters regarding services and facilities. This led to reviewing the frequency of drop in sessions at the school.

Access to the service

The practice was open between 8am and 6.30pm Monday to Friday. GP appointments were from 8.30am (9am on Wednesdays) to 6.30pm (7pm Monday to Thursday). Nurse consultations started at 8.30pm every morning, except Thursday when they started at 8am. In addition to pre-bookable appointments that could be booked up to three months in advance, urgent appointments were also available for patients that needed them.

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

- 89% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 82% and national average of 78%.
- 93% of patients said they could get through easily to the surgery by phone (CCG average 85% and national average 73%).
- 66% of patients said they usually get to see or speak to the GP they prefer (CCG average 47% and national average 36%).

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

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- We saw that information was available to help patients understand the complaints system in the practice booklet, through notices in the patient waiting area and on the practice website.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled, dealt

Good

Are services responsive to people's needs?

(for example, to feedback?)

with in a timely way, with openness and transparency when dealing with the complaint. Lessons were learnt from concerns and complaints and action was taken to as a result to improve the quality of care. For example, a patient had phoned late on a Friday for a prescription to be filled. This was agreed by the GP and sent to the dispensary, which were closing. The dispensary did not fulfil the prescription request and the patient telephoned the out of hours service the following day to have the medication prescribed when they realised their chosen pharmacy had not received the prescription script. Following this the patient complained to the practice. The practice manager apologised to the patient. Systems were then put in place to follow up any end of day prescription requests by GPs with a phone call to the dispensary. The dispensary staff completed a final check of any waiting tasks before closing, to ensure all daily task requests were completed.

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 was displayed in the waiting areas and staff knew and understood the values. The mission statement was: 'To support the patients of Bute House Surgery to lead healthier lives.'
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

Governance and performance management arrangements were actively reviewed and

reflected best practice. The practice had a practice manager and a deputy practice manager to ensure continuity of managerial structure at the practice. The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit which was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions.

Leadership and culture

The partners in the practice had the experience, capacity and capability to run the practice and ensure high quality care. They prioritised safe, high quality and compassionate care. The partners were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff.

The provider was aware of and complied with the requirements of the Duty of Candour. The partners encouraged a culture of openness and honesty. The practice had systems in place for knowing about notifiable safety incidents.

When there were unexpected or unintended safety incidents:

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

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings. We viewed records of the most recent whole staff team minutes, held in March and May 2016. Minutes were comprehensive and showed that significant events, incidents, complaints and complements, safeguarding, infection control and patient issues were standing agenda items. Minutes showed that points for action were discussed in the meetings and signed off when completed. Copies of meeting minutes were available in the staff reception and on the practice computer shared drive.
- 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 in doing so and felt supported if they did.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. Every two months the practice staff attended a practice meeting and staff training. The practice remained open during this time for appointments with a duty doctor. Every three months, the CCG locality made arrangements for staff training 'protected learning.' During this time the practice closed for three hours and was covered by the 111 Dorset out of hours service.
- The practice manager was employed in a mentoring and advisory capacity for other practice managers, such as for practices that were in CQC special measures and in need to improve services to meet regulatory requirements.

Are services well-led?

Good

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

- Staff told us that they believed there was a strong team work ethos at the practice. The staff said bonds were cemented through events such as the annual staff Christmas party and regular staff social outings.

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

The practice encouraged and valued feedback from patients, the public and staff. The practice proactively sought patients' feedback and engaged patients in the delivery of the service.

- Rigorous and constructive challenge from patients who used services, the public and stakeholders was welcomed and seen as a vital way of holding services to account. The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. There was an active virtual PPG with approximately 1,400 members, representing over 19% of the entire practice population and 26% of the adult patient list. The PPG carried out patient surveys and submitted proposals for improvements to the practice management team. For example, in response to PPG members comments new chair raisers were purchased for the patient waiting room that were designed to meet the needs of patients who may have difficulty rising from a sit to stand position. In addition, extra bookable telephone appointments were made available on the day of request for the convenience of patients not needing to attend the practice in person.
- There was strong collaboration and support across all staff and a common focus on improving the quality of care and patients experiences. The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management and thought the practice 'whistle blowing' policy would be effectively implemented should they have concerns about the way the practice was run.

Continuous improvement

There was a strong 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, as part of an over 75s initiative led by one of the partners the practice employed two community health care assistants, who bridged the gap that existed between clinical and social care. Older people were identified in various ways from clinicians, reception staff, frailty measures and outside agencies who may be at risk of hospital admission or if patients had not been seen by surgery staff for more than six months. These patients were comprehensively assessed in their own homes for their social, physical and mental well-being. They were offered an over 75s health check and then discussed at multi-disciplinary meetings to ensure appropriate services were provided. This pilot project started in 2015 and was now being rolled out across North Dorset following the success of the project at Bute House Surgery.