James Fisher Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
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 James Fisher Medical Centre on Wednesday 25 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, recording and learning from any significant events.
- Risks to patients were assessed and well managed.
- Patients said they found it easy to make an appointment with a GP, although two of the patients said this was sometimes harder to do if they wanted an appointment with a specific GP.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- The involvement of other organisations and the local community was integral to how services were planned to make sure the practice met people's needs. For example, the practice worked well with voluntary sector, either through a website signposting or through direct access provided within the practice voluntary suite.
- There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. For example, the practice referred patients including victims of domestic violence, those with mental health problems, and women who have been trafficked to the Sunshine midwifery team for advice and support.
- There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs. For example, the practice offered effective pre-conception advice, on site health visiting team and services of a GP who had a special interest in Paediatrics (GPwSI paeds) who could offer direct support rather than referral to the local hospital.

Summary of findings

- The practice offered contraceptive counselling and services which included lThe GP contraception lead was a faculty registered trainer, who facilitated on-going training for GPs and nurses from other practices.

- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- The practice efficiently identified patients who were carers and offered them written information and guidance and offered ongoing support.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints and concerns.
- 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.
- The practice had provided and offered a room free of charge to voluntary services and charities. The space allowed the practice staff to work in collaboration with a number of local charities to provide services to the local community. Amongst these were the Alzheimer's charity and CRUSE (a bereavement charity).

We saw one area of outstanding practice:

The practice was involved in a collaborative project with two other local practices in response to the needs of the over 75 year population group who were high risk of hospital admission. The project was funded by Dorset clinical commissioning group and known as the Anticipatory Care Team (ACT). The project was aimed at reducing emergency hospital admissions by offering routine care, urgent care, regular reviews and provision of proactive personalised anticipatory care plans for frail older patients who could not easily access practice facilities. We saw data that showed an 11.1% decrease in patients over 75 years attending the emergency department compared to the same period the year before. This related in real terms to 59 less patients being admitted to hospital. Data also showed an 18.2% reduction in self-referral to the emergency department. The team had also provided falls assessments, medicines reviews and, dementia assessments and screening. The team had referred patients for further care and updated care plans.

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 things went wrong patients 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 in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and 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 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 other health care professionals to understand and meet the range and complexity of patients' needs.
- A voluntary sector space had recently opened within the surgery building. The space allowed the practice staff to work effectively and in collaboration with a number of local charities to provide services to the local community. Amongst these were the Alzheimer's charity and CRUSE (a bereavement charity).

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.

Summary of findings

- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding 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 was involved in a collaborative project with two other local practices. The project was aimed at reducing emergency hospital admissions by offering routine and urgent care to frail older patients who could not easily access practice facilities. We saw data that showed significant reductions in patients over 75 years attending the emergency department and being admitted to hospital as an emergency. Data also showed reductions in self-referral to the emergency department.
- The practice were responsive to the needs of people with post-natal depression and significant young person's mental health concerns. Once identified they were referred to services which included the Sunshine team and parenting courses for advice and /support.
- The practice also worked well with voluntary sector, either through a website signposting or through direct access in the practice voluntary suite.
- The practice had responded to the needs of families, young people and children. This included effective pre-conception advice, on site health visiting team and services of a GP who had a special interest in Paediatrics (GPwSI paeds) who could offer direct support rather than referral to the local hospital.
- The practice offered contraceptive counselling and services which included long-acting reversible contraceptives (LARC). The GP contraception lead was a faculty registered trainer, who facilitated on-going training for GPs and nurses from other practices.
- Patients said they found it easy to make an appointment with a GP, although two of the patients said this was sometimes

Summary of findings

harder to do if they wanted an appointment with a specific GP. Patients said there was continuity of care, with urgent appointments available the same day. There were extended hours twice a week
- 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.

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 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.
- 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 notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken
- The practice proactively sought feedback from staff and patients, which it acted on. The 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

Good

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

- The practice offered proactive, personalised care to meet the needs of the older people in its population.

- 1007 patients over 75 years old were registered at the practice which represented approximately 8% of the patient list. These patients all had a named GP and were encouraged to see the same practitioner for regular appointments for continuity. The GPs offered a same day duty triage system to allow most patients to be seen urgently by a practitioner of their choice and offered home visits to all housebound patients.
- The practice used a variety of tools to help identify the most vulnerable elderly patients including local intelligence and specialist computer software. These patients were then reviewed by their GP, where an anticipatory care plan was developed.
- Monthly multidisciplinary team meetings were held to discuss and support the most vulnerable patients. These were attended by representatives from the district nursing team, community matrons, social care and voluntary sector representatives, GPs, practice nurses and the anticipatory care team.
- Patients were offered influenza, shingles and pneumococcal vaccines either in the practice or in the patients' own home. The practice offered screening for dementia and atrial fibrillation during the flu clinics.
- There were established close links with the local nursing home. The GPs visited to review any patients as required.
- The practice worked in collaboration with two local practices and used funding from the Dorset Clinical Commissioning Group to establish an over 75's anticipatory care team. This comprised of a nurse practitioner, registered nurse and administrator. The team provided a proactive service for moderately frail patients, performed comprehensive assessments, maintained anticipatory care plans and also a provided a reactive acute visiting service. The project's aim was to reduce

emergency hospital admissions by identifying potential issues earlier and managing or signposting appropriately. The team currently had 126 active patients representing 12.5% of the practices over 75 population. We saw data that showed an 11.1% decrease in patients over 75 years attending the emergency department compared to the same period the year before. This related in real terms to 59 less patients being admitted to hospital. Data also showed an 18.2% reduction in self-referral to the emergency department. The team had also provided 131 falls assessments, 119 medicines reviews and, 78 dementia assessments and screening. The team had referred 53 patients for further care and updated 116 (74%) care plans.

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.
- The practice monitored and supported people with long term conditions to optimise their health and wellbeing.
- Patients with a long term condition were able to access a named GP. There were same day GP appointments if needed, as well as on the day telephone advice if required.
- Specialist nurses provided dedicated appointments for those with chronic conditions as well as providing telephone support if needed. There were additional clinics working with the community hospital nurse specialist. Patients could access in the practice general nursing, wound dressings, ECG test (heart monitoring), Doppler readings such for leg ulcers, spirometry (breathing assessment), 24 hour BP monitoring, contraception services and immunisations.
- There was a named GP for a local care home who was involved in the long-term management of these patients and provided a point of contact for liaison for staff at the home.

Summary of findings

- The practice had a specialist nursing team particularly for the over 75 year old patients. The team were able to respond to acute problems for this group of patients by visiting at home as well as providing ongoing management of long term conditions.
- Practice staff worked closely with the community matrons who managed patients with more complex healthcare needs in this group. They regularly talked with GPs either face to face or via the computer system. The specialist nursing team and community matrons attend the monthly multidisciplinary team (MDT) meetings where any patients identified as having additional medical or social needs were discussed.
- There was a carers' lead at the practice. Carers were identified at the time of registration or by the GPs or any of the nursing teams. Each carer was provided with a carers' pack which provided information regarding practice contacts, support and other services.
- The practice had a voluntary services hub within the practice which offered support from various voluntary and charity groups.

Families, children and young people

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.
- The practice monitored and supported people with long term conditions to optimise their health and wellbeing.
- Patients with a long term condition were able to access a named GP. There were same day GP appointments if needed, as well as on the day telephone advice if required.
- Specialist nurses provided dedicated appointments for those with chronic conditions as well as providing telephone support if needed. There were additional clinics working with the community hospital nurse specialist. Patients could access in the practice general nursing,

wound dressings, ECG test (heart monitoring), Doppler readings such for leg ulcers, spirometry (breathing assessment), 24 hour BP monitoring, contraception services and immunisations.

- There was a named GP for a local care home who was involved in the long-term management of these patients and provided a point of contact for liaison for staff at the home.
- The practice had a specialist nursing team particularly for the over 75 year old patients. The team were able to respond to acute problems for this group of patients by visiting at home as well as providing ongoing management of long term conditions.
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- There was a carers' lead at the practice. Carers were identified at the time of registration or by the GPs or any of the nursing teams. Each carer was provided with a carers' pack which provided information regarding practice contacts, support and other services.
- The practice had a voluntary services hub within the practice which offered support from various voluntary and charity groups.

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.

Summary of findings

- James Fisher Medical Centre offered GP appointments from 8am in the morning as well as holding two late surgeries until 8pm on Mondays and Tuesdays. Nurse appointments were available until 7.30pm on most Tuesdays.
- Patients could access online booking for appointments and for ordering repeat prescriptions, which allowed people at work to order relevant medicines and organise appointments. There was a facility for patients to view their medical record through the online system.
- In 2015 the practice joined the electronic prescription service enabling GP's to send patient prescriptions electronically to the pharmacy of the patients' choice.
- The GP triage system allowed all patients to have the opportunity to access same day appointments with a GP. This could be telephone or face to face, at the GP's discretion.

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 homeless people, travellers and those with a learning disability.

- 69.4% of patients on the practice learning disability register had attended for an annual health check last year which was in line with local and national averages.
- Vulnerable patients were routinely offered longer appointments and all had a named GP. They had a personalised anticipatory care plan covering physical, mental and social health issues with provision for end of life care planning when appropriate. These care plans were updated regularly and shared with out of hours and emergency services.
- There was same day access for vulnerable patients and their carers via the duty GP service. A system of managed triage appointments encouraged continuity of care.

Summary of findings

- The practice provided a service to several residential facilities including 18 patients at a local disabilities care home. Staff fostered a strong and constructive working relationship with staff at these facilities and aimed to provide continuity of care whenever possible.

- Vulnerable patients with high risk of recurrent admission were discussed at the monthly multidisciplinary team meetings. Proactive personalised anticipatory care plans were in place for each of these patients. These care plans reflected patient identified goals and included information such as a falls risk assessment, medicines management, social and mental health issues and end of life choices. The care plans were shared with other professional and the out of hour's service to ensure good continuity of care.

- Practice staff provided support and reviews for carers. This process had been recently formalised to encourage uptake and engagement. Annual health checks were offered to all carers of patients with dementia.
- Disabled parking, ground floor disabled toilets and waiting room wheelchairs were all available at the practice.
- 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.
- Care for patients who abuse drugs and alcohol was shared between the practice and relevant local agencies.

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 could identify patients experiencing poor mental health including those holding a mental health care plan and those with dementia.
- The practice strived to recognise the difficulties that people experiencing poor mental health and their carers could experience when initiating and accessing ongoing care. Access was supported through planned and

invitation reviews as well as ad hoc review and through the daily GP triage access. Patients of particular concern were identified to the receptionists as 'to be always offered a same day appointment' when they made contact.

- There were active opportunistic screening programmes for dementia. These patients were monitored regularly according to need, as assessed by their usual GP or in conjunction with other services. They were invited for at least an annual review of all physical and mental health needs.
- The practice had introduced an annual health and wellbeing check for all carers of dementia patients, resulting in positive feedback. Many dementia patients were also supported by the practice anticipatory nurse team who helped plan, monitor and organise services. The Memory Assessment Gateway which offered assessment and support at any level of concern to both patient and carers;
- People with post-natal depression and significant young person's mental health concerns were identified through multidisciplinary discussion and monitoring.
- The practice regularly supported patients to access local services including:
- Steps 2 Wellbeing (a comprehensive group and individual support/ counselling and psychotherapy service);
- The Sunshine midwifery team who provided care to vulnerable women, including victims of domestic violence, those with mental health problems, learning difficulties, women who have problems with substance misuse, teenagers and women who have been trafficked.
- Live Well Dorset offering support on physical wellbeing particularly to vulnerable groups;
- Voluntary Sector – either through website signposting or through direct access in the practice voluntary suite.
- The practice worked closely with other professional service including
- Young person's counselling services;
- Community mental health teams (CMHT) and the local pharmacy to regulate medicines in patients with mental health illness when appropriate
- The practice follow up every out of hours contact by one of our patients experiencing poor mental health until they were satisfied that they had addressed concerns.
- A voluntary sector space has recently opened within the surgery building. The space allows the practice staff to

work in collaboration with a number of local charities to provide services to the local community. Amongst these are the Alzheimer's charity and CRUSE (a bereavement charity).

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016 and showed the practice was performing in line or slightly above local and national averages. 249 survey forms were distributed and 117 were returned. This represented about 1% of the practice's patient list.

- 81% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 85%.
- 87% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 80% 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 79%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection.

We received five comment cards. Four of the five cards we received were positive about the service experienced. The other comment card was positive about the current staff but contained negative feedback about an ex member of staff. The four comment cards stated that patients felt the practice offered an excellent service and staff were kind, caring, professional and treated them with dignity and respect.

We spoke with 12 patients during the inspection. All 12 patients said they were satisfied with the care they received and thought staff were kind, caring and professional. We received two negative comments about the occasional delay getting an appointment with a GP of the patients choice.

We saw the results of the friends and family test. In May 90% of the 22 patients would recommend the practice. Comments included specific comments about individual members of staff and general comments including, Excellent service and always a helpful, professional and caring service.

Outstanding practice

The practice was involved in a collaborative project with two other local practices in response to the needs of the over 75 year population group who were high risk of hospital admission. The project was funded by Dorset clinical commissioning group and known as the Anticipatory Care Team (ACT). The project was aimed at reducing emergency hospital admissions by offering routine care, urgent care, regular reviews and provision of proactive personalised anticipatory care plans for frail older patients who could not easily access practice facilities. We saw data that showed an 11.1% decrease in patients over 75 years attending the emergency department compared to the same period the year before. This related in real terms to 59 less patients being admitted to hospital. Data also showed an 18.2% reduction in self-referral to the emergency department. The team had also provided falls assessments, medicines reviews and, dementia assessments and screening. The team had referred patients for further care and updated care plans.

James Fisher Medical Centre

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, a practice manager specialist adviser and an Expert by Experience.

Background to James Fisher Medical Centre

James Fisher Medical Practice was inspected on Wednesday 25 May 2016. This was a comprehensive inspection.

The practice is situated in the town of Bournemouth, Dorset. The practice provides a general medical service to approximately 12,900 patients of a diverse age group. There is ample parking outside the practice and regular bus services in the area.

Information published by Public Health England rates the level of deprivation within the practice population area as eight on a scale of one to ten. Level one represents the highest levels of deprivation and level ten the lowest.

There is a team of nine GPs (six female and three male). Six of these GPs are partners and three are salaried GPs. The GP partners hold managerial and financial responsibility for running the business. The GPs were supported by a practice manager, assistant practice manager, an independent nurse prescriber, six nursing team members and additional administration and reception staff.

Patients using the practice also have access to community nurses, mental health teams and midwives. The health visiting team and an anticipatory care team are based at the practice. Other health care professionals visit the practice on a regular basis.

James Fisher Medical Practice is a training practice for medical students GP trainees and F2 doctors. There are three GP trainers at the practice.

The practice is open to patients between Monday and Friday 8am until 6.30pm. Outside of these times patients are directed to contact the South West Ambulance Service Foundation Trust out of hour's service by using the NHS 111 number.

The practice offer a range ofappointment types including book on the day and advance appointments and can request telephone consultations. Appointments are available for pre-booking up to five weeks in advance and there is a GP triage system for patients wishing to be seen for a same-day appointment. The triage/ duty doctor is available from 8am to 6.30pm Monday to Friday. Patients can book and cancel appointments face to face, online or on the phone. The practice provides 6.50 hours of extended hours appointments each week. These are from 6.30pm – 8pm on Monday and Tuesday evening. These appointments include appointments with the nursing team on Tuesdays.

The practice provided regulated activities from its primary location at 4 Tolpuddle Gardens, Muscliffe, Bournemouth, BH9 3LQ

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 Wednesday 25 May 2016. During our visit we:

- Spoke with a range of staff 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 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 explained that when events occurred there was a supportive culture and the information was promptly managed and used as a learning opportunity.
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events and reported any significant events to external organisations appropriately. For example to the local hospital, public health and NHS England.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, staff had found a vaccine fridge was showing high temperatures. The vaccine stock was deemed unusable after discussion with Health Protection England and Wessex Public Health England. The practice purchased a new fridge and continued the daily checks.

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. These arrangements reflected relevant legislation and local requirements. Policies and flow charts 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 GP 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 on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three. Nurses were trained to level two.
- 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 (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 talked 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. Infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, the last audit in October 2015 prompted staff to review disposal of water used in wound dressings and resulted in a specific decontamination area being introduced.
- 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). 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 there were systems in place to monitor their use. One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for specific clinical conditions. They had received mentorship and support from the medical staff for this extended role.

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.

- The practice held a supply of liquid nitrogen which was appropriately stored with protective clothing and guidance.
- 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.

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 up to date fire risk assessment which had been reviewed in July 2015 and carried out regular fire drills. 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). There had been a risk assessment for legionella performed in August 2015 and staff had been flushing an unused shower on a regular basis. The staff had said they also been testing water temperatures as part of the legionella risk assessment plan but had not been keeping a record of this.
- 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 enough staff were on duty.

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 stored securely. The practice staff were in the process of reviewing the location of the emergency medicines to ensure access was prompt.
- 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. For example, practice nursing staff had easy access to these guidelines, such as treatments for diabetes and childhood immunisations. Staff also used nationally recognised websites for guidance. For example, for travel advice.
- 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 published results for 2014/15 were 98.1% of the total number of points available. The practice manager informed us that for 2015/16 the practice had achieved 98.5% of the points available. (551.01/559)

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators were slightly better than the national average. For example, overall scores were reported at 97.5%. The percentage of patients with diabetes, on the register, who had received an influenza immunisation was 98.41% compared to a CCG average of 94.45%.
- The percentage of patients with normal high blood pressure reading measured in the preceding 12 months was 83.1% compared to a national average of 83.7%.
- The percentage of patients with chronic obstructive pulmonary disease who had a review undertaken in the preceding 12 months was 92.5% compared with a national average of 89.9%.

There was evidence of quality improvement including clinical audit.

- We were shown five clinical audits undertaken in the last two years; two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, and peer review. However there was only a limited audit programme to drive improvement.
- Findings were used by the practice to improve services. For example, an audit was performed to see whether the prescribers in the practice were adhering to clinical guidance for the treatment of sore throats. The first cycle of the audit showed a 75% compliance with NICE guidelines and 27% compliance with primary care guidance. The standard for these was 80% achievement. The GPs discussed these findings and revisited the NICE guidelines. The second cycle of audit subsequently improved to 91% compliance with NICE guidelines and 80% with primary care guidance.

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. Records of this process were kept in the staff files. Staff explained that the induction process had been supportive and had not been time limited but dependent upon when the staff member felt competent to perform their duties.
- 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. For example, practice nurses provided evidence of role specific updates including travel immunisations, immunisations, prescribing and diabetes.
- 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.

- 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, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months. Staff explained that the ongoing support was very good at the practice and said this was provided formally and informally. All staff described mutual respect of each other and described a cohesive team with effective communication.
- 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

Vulnerable patients with high risk of recurrent admission were discussed at the monthly multidisciplinary team meetings where information was effectively shared with other health care professionals. Practice staff worked closely with the community matrons who managed patients with more complex healthcare needs in this group. They regularly talked with GPs either face to face or via the computer system. The specialist nursing team and community matrons attend the monthly multidisciplinary team (MDT) meetings where any patients identified as having additional medical or social needs were discussed. This meeting was coordinated by the MDT facilitator and also attended by representatives from Social Services, Occupational Therapy, hospital liaison and the voluntary sector advisor.

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.
- 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 professionals 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. 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. For example, patients who had been in contact with the out of hours service were reviewed. Following a significant event, the GPs reviewed any interaction of their patients with mental health issues as soon as possible after any treatment or interaction with out of hours providers or emergency departments until their condition was under control.

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 monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. 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 or travel. Patients were signposted to the relevant service.

The practice's uptake for the cervical screening programme was 80.9%, which was comparable to 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

Good

Are services effective?

(for example, treatment is effective)

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. 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.

Childhood immunisation rates for the vaccines given were comparable to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 94.3% to 98.6%, which was in line with local averages. For five year olds the range was reported to be between 94.4% to 98.8%, which was slightly higher than local averages.

Good

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.

Four of the five patient Care Quality Commission comment cards we received were positive about the service experienced. The other comment card was positive about the current staff but contained negative feedback about an ex member of staff. The four comment cards stated that patients felt the practice offered an excellent service and staff were kind, caring, professional and treated them with dignity and respect.

We spoke with three members of the patient participation group (PPG) and nine patients. They also told us they were 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.

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 slightly below for nurses. For example:

- 93% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 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%.
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 87% 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%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

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.

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 for GPs were in line with local and national averages and for nurses, slightly below averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 89% and the national average of 86%.
- 81% 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%.
- 81% 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 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.
- Information leaflets were available in easy read format or could be printed from the computer using large bold print.

Good

Are services caring?

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.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 269 patients as carers (About 2% of the practice list). The practice had a carers coordinator who identified these carers and provided written information to direct carers to the various avenues of support available to them. Carers of patients with dementia were offered health checks.

Staff told us that if families had suffered bereavement, their usual GP contacted them. 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. The practice worked with a bereavement charity and offered a room within the practice free of charge to provide their bereavement counselling service.

Outstanding ☆

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 extended hours on a Monday and Tuesday evening until 8pm for patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability or those whom staff thought needed additional time.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccines available on the NHS.
- There were disabled facilities and a hearing loop had been ordered. Translation services were available.

The practice was involved in a collaborative project with two other local practices. The Anticipatory Care Team project was funded by an over 75's project scheme by Dorset clinical commissioning group. The project was aimed at reducing emergency hospital admissions by offering routine and urgent care, performing regular reviews and providing proactive personalised anticipatory care plans for frail older patients who could not easily access practice facilities. The team consisted of a nurse practitioner and nurse, with an administrator. The nurse practitioner undertook acute visits, allowing prompt assessment and treatment (usually earlier in the day than a GP could visit). We saw data that showed a 3.4% decrease in patients admitted to hospital in the period from January to December 2015 compared to the same period the year before. This related in real terms to 23 less patients being admitted to hospital.

The involvement of other organisations and the local community was integral to how services were planned to make sure the services met people's needs. For example, the practice worked well with the voluntary sector, either through a website signposting or through direct access provided within the practice voluntary suite. Examples seen included dementia charities, bereavement charities and wildlife organisations.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers, particularly for people with multiple and complex needs. The practice referred women to the sunshine midwifery team who provided care to vulnerable women, including victims of domestic violence, those with mental health problems, learning difficulties, women who have problems with substance misuse, teenagers and women who have been trafficked.

There was a proactive approach to understanding the needs of different groups of people and to deliver care in a way that meets these needs. For example, the practice offered effective pre-conception advice, on site health visiting team and services of a GP who had a special interest in Paediatrics (GPwSI paeds) who could offer direct support rather than referral to the local hospital.

Access to the service

The practice offered a range ofappointment types including book on the day and advance appointments. Patients could also request telephone consultations. Appointments were available for pre-booking up to five weeks in advance. The GPs all offered a daily triage system for patients wishing to see their named GP on the same-day. The duty doctor was available from 8am to 6.30pm Monday to Friday. Patients could book and cancel appointments face to face, online or on the phone. The practice provided 6.50 hours of extended hours appointments each week. These were from 6.30pm – 8pm on Monday and Tuesday evening. These appointments include appointments with the nursing team on Tuesdays.

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

- 77% of patients were satisfied with the practice's opening hours compared to the national average of 75%.
- 81% of patients said they could get through easily to the practice by phone compared to the national average of 73%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

People told us on the day of the inspection that they were able to get appointments on the same day when they needed them but sometimes had to wait longer for an appointment with a GP of their choice.

Listening and learning from concerns and complaints

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

- Its complaints 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. For example, posters were displayed in the practice and on the website.

We looked at 14 complaints received in the last 12 months and found these had been satisfactorily handled, dealt with in a timely way, and with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends. Action was taken to as a result to improve the quality of care. For example, a patient was upset with one of the GPs discussion regarding the change of one of their medicines following CCG prescribing advice. The patient was given an appointment with another GP who explained the reasoning behind the change. The original GP wrote to apologise to the patient and as a practice this issue was discussed to decide on how patients could be better informed of CCG prescribing changes.

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 clear aims and objectives and staff knew and understood the values.
- The practice had a robust strategy which reflected the vision and values and were regularly monitored. The GPs were all able to describe future plans regarding the practice which was discussed and recorded within partners meetings if appropriate. However, this was not formalised within a business plan document.

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 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 on the intranet site or within policy files made available to staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous internal audit 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

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. Staff prioritised safe, high quality and compassionate care and were keen to learn from complaints, patient feedback or from significant events. Staff told us the partners and management team were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place 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 partners encouraged a culture of openness and honesty. The practice had systems in place 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.

The practice had a culture of looking at the holistic needs of patients and using alternative support services such as charities to benefit patients. For example, current initiatives included a project encouraging nature walks and bird spotting in conjunction with the RSPB to reduce depression, anxiety and dependency on conventional health services.

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

- Staff told us the practice held regular team 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 personal learning time (PLT) was provided usually four times a year. This PLT was an opportunity where all calls were transferred to the out of hours provider and staff could attend training. For example, a PLT day was being introduced to train staff on a new computer system which was being introduced.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff described mutual respect and appreciation of one another. 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.

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

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

Are services well-led?

Good

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG group were a virtual group and emailed the practice with feedback on issues which had included building work, the introduction of the volunteer and charity hub and response to the content of the practice survey. The PPG members we spoke with said they felt involved in the practice but did not want to be a face to face group, even though they had been asked.
- The practice had gathered feedback from staff through staff meetings, appraisals and informal discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged 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.

The practice had been a training practice for many years. Three of the GPs were trainers and feedback from trainees had been positive. Some of the partners and salaried staff had trained at the practice and had returned.

The practice work collaboratively with other practices in the area. For example, one of the GPs was a director of COMPASS which was a federation of 14 local practices. The aim was to support local population and the GP practices and provide joint approaches to apply to become 'vanguard' sites for the new care models programme to support, improve and integrate services.