Talbot 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.

Summary of findings

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Summary of findings

Overall summary

Talbot Medical Centre is a GP practice with a branch practice located at Bournemouth university. Over 17,000 patients are registered with the practice. A range of services are provided for patients including clinics for the management of long term conditions, family planning and child health. The practice is registered to offer: Family Planning, Maternity and midwifery services, Surgical procedures, Treatment of disease, disorder or injury and Diagnostic and screening procedures.

The patients we spoke with were very positive about the services they received from the practice.

There were systems in place to identify, assess and manage risk and staff were well trained to report any incidents which they felt may compromise safe delivery of care and treatment.

Patients were referred efficiently to local hospitals when they required specialist advice and treatment and GPs received appropriate information to support patients who had attended hospital.

The GP partners and the practice management were supportive and the staff we spoke with told us they found them very approachable. An open management culture was in place and staff were aware of the decisions they could make appropriate to their roles and responsibilities.

Clinical data showed us the practice performed well in delivering care and treatment for patients with long term conditions. The needs of the working age population were recognised because a range of appointment times, including evening appointments, were offered. Mothers babies and young children received services including childhood immunisation clinics and mother and baby checks. Patients at a number of nursing and care homes were registered with GPs at the practice. GPs visited patients at the care homes. GPs were prepared to carry out more home visits to patients recognised as in low income groups to ensure they received appropriate care and support. Sexual health and counselling services were provided for the registered student population.

The inspection took place at The Talbot Medical Centre. We did not visit the branch surgery.

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

The practice was safe. The practice had effective systems in place to provide a safe service to patients. Learning from incidents was shared and actions recorded. Health and safety procedures and risk assessments were kept under review. The practice was clean and well maintained.

Staff had received training in safeguarding children and vulnerable adults and were aware of the process for reporting suspected abuse. GPs had made a decision not to carry controlled drugs in their doctors' bags. All of the information confirming that staff were appropriately qualified and of good character was held in staff files for staff that had been recruited since the practice became subject to regulation.

Emergency procedures and emergency equipment were in place to respond to medical emergencies. Staff were aware of the procedure to follow in an emergency and where the emergency equipment was located.

Are services effective?

The practice was effective. The support for patients identified as requiring palliative care was well coordinated because relevant healthcare professionals were involved. Access to services appropriate to patients with varying needs was available. For example there was a counselling service in place, operated by the local Trust, at the branch surgery. Patients we spoke with told us that they could obtain repeat medicines efficiently and effectively and that they were able to get test results in a timely manner. The practice undertook clinical audits of treatment and prescribing of medicines. The practice promoted and supported clinical and non-clinical training. GPs and staff we spoke with told us how they kept up-to-date with clinical and management developments by attending training courses and using staff meetings to share knowledge.

Are services caring?

The practice was caring. The practice demonstrated a caring approach. Patients were extremely positive about the care they received. The patients' view that practice staff were caring was reflected in the local patient survey, on comment cards we reviewed and by patients we spoke with on the day of inspection. We saw that staff were caring and respectful in their interactions with patients. Patients we spoke with told us how they were involved in making

Summary of findings

decisions about their care. The GPs we spoke with told us that care plans were drawn up in consultation with the patient. We saw that attention was paid to privacy and dignity. We saw that telephone calls from patients booking appointments were taken in a call centre room where they could not be overheard by others. Information for patients about how their records and personal information was kept and used was displayed at the reception and on the practice website. This included information on how patients could access their own records

Are services responsive to people's needs?

The practice was responsive to patients' needs. There was a clear complaints policy and patients we spoke with told us they felt able to offer comments about the service they received. However, the complaints policy was not provided in written form in either the waiting room or at the reception. Advice about how to make a complaint was available via a display screen in the waiting room.

The practice understood the different needs of the population it served and acted on these to ensure the service they provided offered appropriate support. The practice participated in discussions with local commissioners about how to improve services for patients in the locality.

The practice offered appropriate access for patients with mobility difficulties. An induction loop (a system to amplify voice) was available for patients who had hearing difficulties. Written information about practice services and specific health conditions was available for patients with visual impairment.

Are services well-led?

The practice was well led. Staff were aware of their roles and what decisions they could make. Practice management and GPs demonstrated strong leadership and a commitment to their patients and staff.

Development and improvement among clinicians and staff was supported by an effective performance review process and by a visible commitment to training. Governance structures were in place and systems to manage risks and monitor the quality of service were evident. The practice sought feedback from patients and acted on the information they received.

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

Compared to other practices in the Bournemouth area the practice had a lower than average number of older patients registered. However, there was evidence that effective services were delivered. The Quality and Outcomes Framework (QOF) data we reviewed showed good performance in managing long term medical conditions associated with patients over the age of 75. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. All patients aged over 75 had been allocated a named GP. Care for older people was regularly reviewed.

We saw that patients living in care and nursing homes were identified and well known to GPs. Systems to respond to the needs of patients residing in care and nursing homes were in place. GPs had time built in to their schedules to support patients living in care homes.

Access to the practice premises was appropriate for older patients. All treatment and consulting rooms were on the ground floor.

We spoke with some patients who were over 75. They told us they found the GPs and Nurses were caring and considerate when addressing their care and treatment needs.

People with long-term conditions

The practice supported patients with long term conditions. Disease registers were maintained that identified patients with long term conditions. There were recall systems in place to ensure patients with long term conditions received monitoring and support. The practice had achieved over 99% of the targets for managing long term conditions in the Quality and Outcomes Framework (QOF).

We were told of patients with multiple long term conditions who came to the surgery for one review appointment to avoid multiple visits. This showed us that the practice was aware that visiting the practice can be difficult for patients with long term health conditions.

Patients with long term medical conditions had care plans in place. Patients we spoke with told us that their care plans had been developed with their involvement and that they understood their

plan. They told us that if their care plan required amendment they were involved in the changes. We also heard that when patients attended for their health checks they were treated with care and respect and felt they were listened to.

The practice was proactive in monitoring prevalence of long term medical conditions. Work had been undertaken to identify 300 patients who could develop a higher dependence on health care treatment and support. These patients were involved in the development of their care plans. The patients had been chosen in response to a national project aimed at reducing the need for future admission to hospital.

Mothers, babies, children and young people

The practice worked closely with other health care professionals to deliver care and treatment to mothers and younger patients. The practice had effective chaperone and safeguarding children policies which supported this population group. Staff we spoke with were able to tell us how they would identify a potential sign of abuse.

We saw that the practice delivered childhood immunisations in line with national targets and that mother and baby health checks were carried out. There was a system in place to alert health visitors if a mother and baby failed to attend for their health check.

Students at Bournemouth university were able to access the sexual health clinics and counselling services available at the practice. We were told by the GPs and nurses we spoke with that family planning advice and support was offered to university students.

The GPs worked with named midwives. Midwives attended the surgery to support expectant mothers through their pregnancy. Close liaison between GPs and midwives was made easier when discussion was needed to support a pregnant woman. We were told more women were opting for home births and the GPs and midwives were supportive when this choice was made. Advice on risks of home births was offered when appropriate.

The working-age population and those recently retired

The practice offered care and treatment to this group of patients. The practice had a higher than average number of patients aged between 19 and 24 than other practices in the Bournemouth area. This was mainly due to the large number of students registered with the practice.

Services were responsive to this group with a range of appointments available at two locations. Telephone consultations were available

for patients who were unable to attend the practice due to other commitments. Evening clinics were held on two evenings every week. The facility to book an appointment online was available for patients who could not make a telephone booking.

There was service provision specific to the needs of these patients. This included; family planning, counselling, travel clinics and cervical cytology screening.

At the start of the university term a team of staff attended the branch surgery to offer advice on registering with the practice and assist new students to register.

There was evidence that management and the GPs kept service delivery under review. We saw the appointment system had been developed to offer more on the day appointments at times of higher demand. For example, on a Monday morning. GP allocation had been managed to ensure patients could access either a male or female GP at both sites throughout the week.

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

The practice made significant efforts to identify and support patients who may be vulnerable, or from a disadvantaged background.

Arrangements were in place to ensure patients with a learning disability received an annual health check. A register of patients with a learning disability was in place. Continuity of care was maintained for this group because they had a named GP who knew them well.

Patients identified as suffering income deprivation were known to GPs and staff and arrangements were made to ensure they received access to care and support. For example, the GPs carried out home visits for patients unable to afford to travel to the practice.

The practice had an open registration policy. No patient wishing to register with the practice would be turned away.

GPs and staff at the practice knew their patients very well. Both were able to tell us about patients they knew who required additional care and support to meet their needs. Staff told us of patients they knew who on any occasion when they presented with minor health problems would be given urgent appointments to see their usual GP.

People experiencing poor mental health

The practice supported services for patients experiencing mental health problems. Patients with long term mental health conditions were identified on practice registers. The practice had achieved

maximum points in the Quality and Outcomes Framework (QOF) domains for mental health care and support. The physical care needs of patients with mental health problems were addressed by carrying out the tests and reviews included in national good practice guidance.

We saw that the practice worked with both the local community mental health team and the child and adolescent mental health service. When the need for specialist support from either of these teams was identified a referral was made.

Counselling services were available and GPs referred patients to these services when appropriate.

Summary of findings

What people who use the service say

We spoke with 18 patients during the inspection. We also received 20 comment cards from patients who had visited the practice in the previous two weeks. In addition, we received two e-mails from patients who were aware that the inspection was going to take place. All of the patients who submitted their views had positive things to tell us about the services they received. There were four comments related to individual views that we fed back to the practice for their consideration.

We also looked at the results of the latest national GP survey. 92% of the 296 patients who answered this question rated the service as good or very good. The feedback left by three patients on the National NHS Choices website was 100% positive resulting in a five star rating for the practice.

Areas for improvement

Action the service COULD take to improve

- The practice could ensure that the complaints procedure is available in a written format in the patient areas.
- The practice could make sure that the patient call system is reviewed as it was not always clear which patient was being called for their appointment

Good practice

Our inspection team highlighted the following areas of good practice:

- The practice was involved in local audits that compared outcomes for patients from practices within the clinical commissioning group.
- The GP partner with responsibility for safeguarding attended the safeguarding board meetings.
- GPs carried out home visits for patients unable to afford to travel to the practice.

Talbot Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and a GP specialist advisor. The team included a second CQC inspector and an expert by experience. Experts by experience are members of the team who have received care and experienced treatment from similar services.

Background to Talbot Medical Centre

Talbot Medical Centre is located in the Wallisdown area of Bournemouth. The practice was built in the 1970s and has been expanded since it was first constructed. There is a branch practice located at Bournemouth university providing medical services for students.

The practice provides a range of primary medical services to over 17,000 patients. During university terms over 7,000 patients are university students. The practice performs well against nationally recognised quality standards. Clinical outcomes data shows over 99% of targets were met. Feedback from patients is generally positive with 92% of 296 patients who took part in a national survey rating services as good or very good.

Care and treatment is delivered by a 11 GPs, a nurse practitioner, four practice nurses and three health care assistants. The clinical team are supported by the practice manager, the deputy practice manager and a team of 10 receptionists, three administration assistants, two medical secretaries and a personal assistant. The practice is a member of Dorset Clinical Commissioning Group (CCG). One of the GPs and the practice manager are members of the locality board of the CCG.

Why we carried out this inspection

We inspected this GP practice as part of our new inspection programme to test our approach going forward. This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before visiting, we reviewed a range of information we had received from the practice. We also received information from local organisations, such as NHS England, Healthwatch and the Dorset Clinical Commissioning Group (CCG). We carried out an announced visit on 2nd June 2014.

During our visit we spoke with a range of staff, including GPs, practice nurses, the practice manager and administration staff. We observed how patients were cared for and how staff interacted with patients. We also spoke with patients who used the service. We reviewed management records.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older people (over 75s)

Detailed findings

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

Are services safe?

Summary of findings

The practice was safe. The practice had effective systems in place to provide a safe service to patients. Learning from incidents was shared and actions recorded. Health and safety procedures and risk assessments were kept under review. The practice was clean and well maintained.

Staff had received training in safeguarding children and vulnerable adults and were aware of the process for reporting suspected abuse. GPs had made a decision not to carry controlled drugs in their doctors' bags. All of the information confirming that staff were appropriately qualified and of good character was held in staff files for staff that had been recruited since the practice became subject to regulation.

Emergency procedures and emergency equipment were in place to respond to medical emergencies. Staff were aware of the procedure to follow in an emergency and where the emergency equipment was located.

Our findings

Learning from incidents

We saw that the practice carried out regular reviews of significant events. The records we saw showed us that full investigation of any significant event was carried out. Learning from the incident was shared with all partners, practice management and relevant staff. Staff confirmed that the learning from incidents was shared with them. We saw that the practice had systems in place to reduce the likelihood of significant events being repeated.

Safeguarding

Children and vulnerable adults were protected from the risk of abuse because the practice had taken reasonable steps to identify and prevent abuse from happening. There were systems in place to identify those patients who may be at risk. We spoke with the lead GP responsible for safeguarding. They told us about the procedures in place to identify and report possible abuse and gave us some examples of safeguarding referrals that had been made. We saw safeguarding was a standing agenda item on the weekly practice team meeting. There was evidence that the practice took part in clinical commissioning group (CCG) wide audit of safeguarding referrals and took an active role in attending safeguarding board meetings within the CCG.

We saw that all staff received an appropriate level of training for protecting children and vulnerable adults. Staff we spoke with were able to tell us about the forms of abuse they might identify during their duties and how they would report any concerns. There were practice safeguarding policies and procedures in place. These included very clear guidance on what to report, when to report and to whom suspicions of abuse should be reported to. Staff told us that they would raise a safeguarding concern either with the lead GP or with the practice manager.

Medicines management

The practice kept a minimal supply of medicines. GPs did not carry controlled drugs in their doctor's bags. Medicines were monitored and recorded. A lead nurse was responsible for medicines management and the expiry dates of any medicines held were recorded. This enabled the lead nurse to ensure stock was in date and suitable for use. There were procedures in place for the safe disposal of out of date medicines.

Are services safe?

Any medicine related issues were reported appropriately to external organisations and were recorded as significant events. These were discussed at clinical meetings and actions taken to prevent re-occurrence. There was a procedure in place to respond to national medicine alerts. In the event that a medicine was identified that needed to be withdrawn from use or the dosage adjusted, a list of patients on the medicine in question was extracted from the patient database. Patients were called in to see their GP to ensure the appropriate change in their medicine was made and this was recorded in the patient medical record.

Vaccines were stored appropriately in dedicated vaccine fridges. These fridges were subject to daily temperature checks to ensure the vaccines were stored at the correct temperatures. We were told of the actions the practice took when one fridge was found to have been accidentally switched off. The actions were robust, including checking vaccine viability with the manufacturer, and ensured the disposal of any vaccines as required. The practice was aware of vaccine safety and took action if there was any doubt that vaccines may have been rendered unsafe for use.

Cleanliness and infection control

There were effective systems in place to reduce the risk and spread of infection. The practice had an infection control lead and appropriate policies and procedures.

Hand washing guidance was available adjacent to the sinks in treatment rooms and toilets. Soap and appropriate hand drying facilities were available at every sink throughout the practice. There was an adequate supply of disposable gloves and other personal protective equipment (PPE). Staff were aware of when to use PPE.

Work surfaces in treatment and consulting rooms were clutter free. The work surfaces in treatment rooms were generally in good repair and easy to clean.

Patients were cared for in a clean, tidy and hygienic environment. All areas of the practice were visibly clean and tidy on the day of our inspection. We looked at the cleaning schedule for the practice. This showed us the frequency that each area was required to be cleaned and described what sort of cleaning was needed. For example, areas were identified that needed to be cleaned and how often. The cleaning contractor and practice management carried out a quality check each month and recorded the findings. Any shortfall in cleaning standards was rectified and recorded. There were records of the cleaning products in use and where they should be used.

Staffing and recruitment

We found effective recruitment and selection processes were in place. These followed a set recruitment and selection protocol. Practice management told us that all staff were taken through a formal recruitment process consisting of completion of an application form and formal interview. We saw records that confirmed this. The practice manager told us that any gaps in employment history were fully investigated.

Appropriate checks were undertaken before staff started work at the practice. References were sought and obtained and copies of identification checks were held on staff personnel files. The practice manager had carried out a risk assessment which identified staff that required a criminal records check through the Disclosure and Barring Service (DBS) (previously Criminal Records Bureau (CRB)). Records we reviewed showed that appropriate checks had been carried out. Staff turnover at the practice was low and most of the staff we spoke with had been working at the practice for many years. Staff who had been recruited in recent years told us they had been taken through the recruitment process the practice manager had described to us.

Dealing with Emergencies

Appropriate equipment, medicines and oxygen was available for use in a medical emergency. The emergency equipment was checked regularly. We saw evidence of these checks and when a check identified a need for repair or replacement this had been carried out. There was a comprehensive plan in place to deal with situations that might affect delivery of patient care. This business continuity plan included what to do if the building became unusable for any reason. Staff we spoke with were aware of this plan and their role in dealing with situations that might arise that interrupted services to patients.

Equipment

We saw records that confirmed essential equipment had been serviced and maintained in accordance with manufacturer's instructions. The records also showed us equipment requiring regular calibration had been calibrated.

Are services safe?

There were records of maintenance of essential building plant and equipment being serviced at the appropriate intervals and in accordance with legislation. For example the fire alarm system was serviced and tested.

Are services effective?

(for example, treatment is effective)

Summary of findings

The practice was effective. The support for patients identified as requiring palliative care was well coordinated because relevant healthcare professionals were involved. Access to services appropriate to patients with varying needs was available. For example there was a counselling service in place, operated by the local Trust, at the branch surgery. Patients we spoke with told us that they could obtain repeat medicines efficiently and effectively and that they were able to get test results in a timely manner. The practice undertook clinical audits of treatment and prescribing of medicines. The practice promoted and supported clinical and non-clinical training. GPs and staff we spoke with told us how they kept up-to-date with clinical and management developments by attending training courses and using staff meetings to share knowledge.

Our findings

Promoting best practice

Care and treatment was delivered in line with recognised best practice standards and guidelines. There was evidence the practice kept up to date with new guidance and legislation. Clinicians followed the relevant National Institute for Health and Care Excellence (NICE) guidelines in the management of patients with long term medical conditions. The protocols to follow were embedded in the practice database.

Clinicians were clear about how they would apply the Mental Capacity Act 2005 (MCA) and how they would assess mental capacity. Patients who were either unable or found it difficult to make an informed decision about their care could be supported. We were told how GPs involved Independent Mental Capacity Advocacy (IMCA) services to support patients in decision making.

The practice took part in local prescribing audits. This meant that the practice was able to compare their prescribing with other GP practices in the area and review whether patients were receiving the right medicines at the right dosage.

Monitoring outcomes of care

The practice participated fully in all recognised benchmarking programmes both nationally and locally. This included Quality and Outcomes Framework (QOF), local and direct enhanced services and local peer reviews. The QOF is a voluntary incentive scheme for GP practices in the UK, rewarding them for how well they care for patients. We found evidence to support this.

Clinical audits were carried out and reviewed regularly. We saw actions were taken to address clinical indicators where the practice was identified as an outlier. Action was also taken when areas for improvement were identified from practice audits. QOF results showed over 99% achievement. For example, the practice had investigated why the incidence of Chronic Obstructive Pulmonary Disease (COPD) (this is a condition where the patient experiences severe shortage of breath) was lower than average and admissions to hospital of patients with COPD were higher than average. We saw the practice had conducted intensive analysis of their patient list and could draw no definitive conclusion as to why the recorded numbers of patients with COPD were lower than average.

Are services effective?

(for example, treatment is effective)

The practice had conducted a screening exercise by recalling patients who smoked and had presented with chest infections to find out if COPD was the cause. We saw that the practice worked closely with the community pulmonary nurse to follow up patients with COPD who had been admitted to hospital.

An annual audit of minor surgery was undertaken. We saw this had identified the need to ensure all patients gave written consent to any minor surgery procedure requiring an excision. GPs were aware of the outcome and were focused upon ensuring written consent was gained. Services to patients were reviewed to ensure best practice was achieved. Where action to further improve and enhance service was identified from re auditing the changes the practice took action.

Staffing

Staff we spoke with told us about their induction and confirmed it was comprehensive and prepared them for their roles. We saw induction checklists held in personnel files. These were well structured and tailored to the staff member's role.

There was an emphasis on training at the practice. All the staff we spoke with told us that training was comprehensive and tailored to the requirements of their roles. There was a training plan in place that identified when training had taken place and when refresher training was due. The training plan included mandatory and essential training. It showed us that staff had completed training in safeguarding and basic life support. We saw that certificates confirming staff had completed training were held in their personnel files.

We saw that staff received an annual appraisal. Staff told us they found their appraisals were useful. The appraisal included a review of the previous year's performance, identification of training needs and setting some goals for the coming year. Nursing staff did not receive regular supervision but told us they received updating and support from the nursing team leader. The lead nurse received an annual appraisal from the practice manager and a GP.

Continuing professional development and training was available to clinical staff. Training was identified during staff appraisals. GPs and nursing staff we spoke with told us about training they had undertaken.

Working with other services

We saw the practice engaged with other health and social care providers to meet patient needs. Regular liaison with other providers, such as the local community mental health team, was evident from minutes of meetings of multidisciplinary teams. GPs had good professional working arrangements in place with health visitors, district nurses and local midwives. We saw the practice delivered care for residents in local care homes and for a number of people with learning difficulties living in the community. Housebound patients were well supported by the practice because home visits were undertaken when required.

Promoting health and wellbeing

Health promotion material in written format was not displayed in either the waiting room or reception area. Patients attending the practice could not access health promotion materials on an opportunistic basis. If a patient wanted to follow up health promotion information displayed on the screen in the waiting room they had to ask for written material or speak with a GP or nurse. Clinical staff we spoke with told us that health promotion was offered on an individual basis at the time of consultation. We saw there was a range of health promotion information available in treatment rooms and that the practice made use of similar materials downloaded from national websites. Patients we spoke with told us they received health and wellbeing advice. The smoking cessation service available at the practice was complimented by some of the patients we spoke with.

The practice website contains a page entitled "Looking after yourself" which featured a range of healthy lifestyle advice and links to other webpages which provided advice and support for health and wellbeing. Patients with access to a computer could, therefore, obtain health and wellbeing advice online.

Are services caring?

Summary of findings

The practice was caring. The practice demonstrated a caring approach. Patients were extremely positive about the care they received. The patients' view that practice staff were caring was reflected in the local patient survey, on comment cards we reviewed and by patients we spoke with on the day of inspection. We saw that staff were caring and respectful in their interactions with patients. Patients we spoke with told us how they were involved in making decisions about their care. The GPs we spoke with told us that care plans were drawn up in consultation with the patient. We saw that attention was paid to privacy and dignity. We saw that telephone calls from patients booking appointments were taken in a call centre room where they could not be overheard by others. Information for patients about how their records and personal information was kept and used was displayed at the reception and on the practice website. This included information on how patients could access their own records.

Our findings

Respect, Dignity, Compassion and Empathy

We spoke with 18 patients on the day of our inspection. Patients told us they had been listened to by both GPs and nurses and that their care and treatment met their needs. Patients also told us that staff were professional and friendly. Some patients told us the GPs and nurses were good at making time for them and that they never felt rushed when attending for their appointments. The practice, in partnership with the patient reference group (a group of patients registered with the practice who have an interest in the services provided), conducted an annual patient survey. The results of the survey were made available to patients both in hard copy and on the practice website. We looked at the last set of results from this local survey and saw that patients were generally very positive about the service they received.

Before the inspection took place we asked patients to complete comment cards to tell us about their experience of the care and treatment offered. We also received two e-mails from patients who were aware our inspection was taking place. We received 20 completed cards. Every comment card contained positive comments and reflected a high level of satisfaction with the service received. We received two comments relating to the waiting room not being overly welcoming. The practice manager and registered manager told us they would look at the layout and décor.

We looked at the results of the last national patient survey, carried out between January and September 2013, which collected the views of patients who used Talbot Medical Centre. Patients were positive about the service they received. 92% of 296 patients rated the service as good or very good. 80% of 299 patients would recommend Talbot Medical Centre to their friends and families. 88% of 299 patients rated their experience of making an appointment as good or very good.

GPs and staff demonstrated a strong awareness of the need to maintain patient confidentiality and of the practice policy on confidentiality. We saw calls from patients wishing to book an appointment or ask any questions about their care and treatment were taken in a dedicated call handling room. This was away from the reception and therefore, calls could not be overheard by other patients in the waiting room. Staff we spoke with told us taking patient

Are services caring?

calls in a dedicated room helped them to feel confident that confidentiality could be maintained. We saw that doors to both consulting rooms and treatment rooms were kept closed during patient care and treatment.

Information for patients about how their records and personal information was kept and used was displayed at the reception and on the practice website. This included information on how patients could access their own records.

Staff were able to tell us about patients they knew required prompt support to help them with their care and treatment. Staff we spoke with told us that this group of patients were always offered an appointment on the day they made contact. These patients were not caused distress in waiting for advice or treatment.

Involvement in decisions and consent

The staff we spoke with showed a keen desire to deliver patient centred care. Both the GPs and staff we spoke with told us about how they were aware of individual patient needs. The patients we spoke with were positive about staff attitudes to their care and many felt they benefitted from the GPs having a detailed knowledge of their long term care needs and their medical history.

The GPs we spoke with told us that care plans were drawn up in consultation with the patient. GPs also told us, and patients confirmed, that decisions about care and treatment were made in discussion with the patient. Patients we spoke with told us they felt fully involved in how their care and treatment was managed.

Are services responsive to people's needs?

(for example, to feedback?)

Summary of findings

The practice was responsive to patients' needs. There was a clear complaints policy and patients we spoke with told us they felt able to offer comments about the service they received. However, the complaints policy was not provided in written form in either the waiting room or at the reception. Advice about how to make a complaint was available via a display screen in the waiting room.

The practice understood the different needs of the population it served and acted on these to ensure the service they provided offered appropriate support. The practice participated in discussions with local commissioners about how to improve services for patients in the locality.

The practice offered appropriate access for patients with mobility difficulties. An induction loop (a system to amplify voice) was available for patients who had hearing difficulties. Written information about practice services and specific health conditions was available for patients with visual impairment.

Our findings

Responding to and meeting patient's needs

The practice had a large student population. Services were provided at a branch surgery located at Bournemouth university. Counselling and sexual health clinics were available at the branch surgery to meet the needs of this patient group. GPs from the practice visited patients in local care and nursing homes and strong links had been built with these homes. The practice recognised the needs of patients on low incomes. GPs undertook more house calls to this group of patients who often found it difficult to attend the practice. The GPs were very aware of people with learning difficulties who were registered with the practice. Systems were in place to ensure this group of patients received an annual health check-up.

Access to the service

There were a range of appointments available to patients every weekday between the hours of 8:30am and 6:30pm. Extended hours surgeries were held on both Tuesday and Thursday evenings up to 8:15pm. These were held at the main practice site but appointments were available to all registered patients. Patients were able to book appointments in person, by telephone or online. All on the day appointments were made available at 8am for all methods of booking. We also saw that the practice appointment timetable included telephone consultation times which could be accessed by patients who were unable to attend the practice.

We observed the staff working in the dedicated call centre. We saw that patients requesting an on the day appointment received an appointment that day. Non-clinical staff booking appointments told us, and we observed, they did not seek detailed clinical information before allocating an on the day appointment. Patients we spoke with on the day of inspection were generally happy with the access arrangements to appointments with both GPs and nurses.

There was evidence that the practice responded to patient comments about access to services. We saw patients, who contributed to one of the patient representative group (PRG) surveys, (A PRG is a group of patients who have volunteered to be in electronic communication with the practice because they take an interest in service developments), had commented the telephone number used for appointment booking was costly to use and that it

Are services responsive to people's needs?

(for example, to feedback?)

took too long to get through to book an appointment. The practice had changed the telephone number to a local number and had reorganised staffing to have more staff available to answer the phones at peak times. Therefore, patients waited less time for their calls to be answered and were able to access a less expensive telephone number.

Concerns and complaints

Patients' comments and complaints were listened to and acted upon. There was a clear complaints policy and procedure. This was available to patients in both the practice leaflet and on the practice website. However, it was not displayed in either the waiting room or reception. This meant a patient who wished to make a complaint would have to ask for a copy of the procedure from a member of staff or find it from one of the above sources. The opportunity to make an anonymous complaint was reduced for this reason. Some of the patients we spoke with told us they were not aware of the complaints procedure and would have to ask a member if they felt the need to raise a concern or lodge a complaint.

There was a high level of patient satisfaction with the services provided. This was evidenced by the national patient survey, the practice surveys and by the patients we spoke with. Therefore, very few complaints were received. The complaints we saw from patients had been fully investigated and responses had been given to the patient. All complaints we saw recorded had been dealt with in a timely manner and in line with the practice complaints procedure. Any action arising from a complaint which could reduce the risk of similar complaints arising in the future was discussed with relevant staff.

Are services well-led?

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

Summary of findings

The practice was well led. Staff were aware of their roles and what decisions they could make. Practice management and GPs demonstrated strong leadership and a commitment to their patients and staff.

Development and improvement among clinicians and staff was supported by an effective performance review process and by a visible commitment to training. Governance structures were in place and systems to manage risks and monitor the quality of service were evident. The practice sought feedback from patients and acted on the information they received.

Our findings

Leadership and culture

There was visible leadership within the practice. Staff told us the practice manager kept them informed of developments within the practice both informally and formally via team meetings. We spoke with four GPs who were clear about the practice priorities and goals. Openness and transparency of management was apparent, demonstrated by minutes of team meetings. Staff we spoke with told us they appreciated the involvement of GPs in their team meetings.

The practice had a clear and evident ethos to deliver good quality service for all patients in a timely manner. When we spoke with clinicians and non-clinical staff all were clear about the practice ethos and our observations supported this. For example, non-clinical staff were very clear that they did not have a role in assessing clinical priorities for on the day appointments. The practice nurses we spoke with told us how they sought immediate GP support for patients who required care and treatment only a GP could provide. We were told that patients would get the GP support and advice they needed without having to return for a further appointment. Policies, guidelines, protocols and minutes of meetings all demonstrated the core values.

Governance arrangements

There were effective arrangements in place to ensure that responsibilities were clear, quality and performance were considered and managed and risks were identified and managed. We saw notes of strategy meetings held by the senior leadership team on a quarterly basis. These evidenced that the practice reviewed their strategy to ensure it was not out of line with local commissioning priorities.

We saw that GPs held responsibility for specific aspects of clinical and general management and took time to discharge these responsibilities. One of the GP partners held the overall management lead and they and the practice manager told us how they worked closely together to ensure good governance. Staff we spoke with told us that GPs were present at team meetings and that this was appreciated as it fostered direct lines of communication.

Are services well-led?

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

Systems to monitor and improve quality and improvement

We spoke with four GPs and two practice nurses. All six were clear in their primary role to deliver safe and effective care. Staff we spoke with were aware of the practice's whistleblowing policy and would not hesitate to alert senior management of any concerns they had related to suspected poor or bad practice. There was an audit programme in place which covered both clinical and management topics. For example, we saw a clinical audit which assessed the success rate of taking cervical smears. The audit analysed the success rate of the different clinicians that took cervical smear tests. There was evidence that the results had been shared with clinicians and action identified for improvement. A further audit was planned to evaluate the changes.

Learning and improvement

We saw evidence of performance management and appraisal routinely undertaken with both clinical and non-clinical staff. Clinicians used the Quality and Outcomes Framework (QOF) data to drive improvements in management of patients with long term conditions. The practice took part in local initiatives, such as reviewing referrals to local hospitals, instigated by the Clinical Commissioning Group (CCG). Systems were in place for staff to identify when they needed additional training or resources and the practice responded by providing these.

All staff were briefed on how to report an incident. There was a significant event procedure in place. The practice manager and the GP partner with management responsibility ensured all incidents were investigated and learning identified to reduce the risk of a similar occurrence in the future. Any actions identified were taken and the action recorded. The action and learning from significant events was shared with the individual or the relevant team. Staff we spoke with confirmed they were briefed on the actions required when it was appropriate to their role.

Patient Experience and Involvement

The practice actively sought patient feedback and acted upon patients views. The practice manager was aware of the results of the national patient survey and knew the level of overall satisfaction from the 2013 results. Management maintained communication with the patient representative group (A PRG is a group of patients who have volunteered to be in electronic communication with the practice because they take an interest in service developments). We spoke with two patients who were members of the PRG. They told us that they had open communication with the practice management and felt they were listened to. PRG members took part in the practice initiated annual survey. We saw that when the last survey identified that patients were concerned about the cost of using the previous practice telephone number the practice changed the number to a local line. The practice had trialled an appointments system whereby all patients received a call from a GP before a face-to-face consultation was arranged. When patients fed back that they did not like this system the practice ceased the trial.

The patients we spoke with and those who completed our comment cards all had positive comments to make about the care and treatment they received from the practice.

Staff engagement and involvement

Regular team meetings were held. For example administration team meetings and nursing team meetings. The records of these meetings showed us GPs were directly involved in discussions with their staff. Staff we spoke with told us they felt able to contribute to the management of the practice because the GPs and management were open to their involvement and took action on their input. We heard how the practice had trialled an alternative appointment system whereby all patient requests for appointments were triaged by the GPs. The trial was evaluated by the practice team and we heard that the majority of staff and GPs had felt the system was not working to patient and staff benefit. The practice ceased the trial and returned to a more traditional appointment system.

Identification and management of risk

The practice had a broad ranging set of health and safety policies in place. We saw these were supported by risk assessments. Staff we spoke with were aware of the practice safety policies and some had received training to support them in safe working practices. For example some staff had received training in lifting and handling. The business continuity plan identified the range of risks the practice could face that would prevent the delivery of care and treatment. The plan identified how these risks would be mitigated and actions needed to restore services to patients.

There were records showing that building maintenance was carried out and that a planned redecoration programme was in place. We saw invoices confirming that

Are services well-led?

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

building plant such as the gas boiler had been subject to appropriate servicing and certification. We also saw records confirming that equipment maintenance and calibration had been carried out in accordance with manufacturers' instructions.