# Locality Health Centre

## Quality Report

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Weston-Super-Mare
North Somerset
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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 | Outstanding ☆ |
| Are services safe? | Good ● |
| Are services effective? | Outstanding ☆ |
| Are services caring? | Good ● |
| Are services responsive to people's needs? | Outstanding ☆ |
| Are services well-led? | Outstanding ☆ |

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

We carried out an announced comprehensive inspection at Locality Health Centre on 9 April 2015. Overall the practice is rated as Outstanding.

Specifically, we found the practice to be outstanding for providing responsive, effective services and for being well led. It was also outstanding for providing services for older patients, families, children and young people and people whose circumstances may make them vulnerable. There were also elements of outstanding practice for other patients.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the practice maximised ease of access for patients by encouraging other services to operate from the centre, these currently include, pulmonary rehabilitation, retinal screening, and a heart failure nurse service.
- Risks to patients were assessed and well managed, with the exception of those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients were treated holistically in an environment which provided access to a range of community based services which supported their wellbeing.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.

# Summary of findings

- Patients said they generally found it easy to make an appointment and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice:

- To help address concerns about pregnancy in young people the nurse, who is also the 'No Worries' advisor, visited a local school to advise on contraception and pregnancy avoidance. The nurse also .ran a specific clinic about sexual health each Wednesday for young people under the age of 21 years. The co-location of the practice with the children's family services, 'Troubled Family' team, family nurse practitioners, health trainers and being part of the new Bournville One Police initiative ensures the practice is integrated into other services and information sharing took place with very local services. The Centre also operates a food bank to which the practice refers families.
- The practice experiences a very high appointment demand for conditions of low mood and anxiety. These demands are met by GPs and nurses working in partnership with other organisations the wellbeing worker employed in the centre. These support sessions played a key role in the emotional support of patients and helped re-able patients.
- The practice shared facilities with the Healthy Living Centre. Facilities included a church, a café, a library, a nursery, a 'shop' and a clothing bank as well as other community spaces. The clothing is brought to the shop and resold, it is also given away at the clothing bank to those in need. Funds raised go towards supporting a local food bank which currently supports approximately 70 of the practices patients. The 'shop', located adjacent to the practice waiting area, supplies fruit and vegetables which are not easily available locally. Patients are often encouraged to use this facility by the clinical team as part of healthy lifestyle advice. All aspects of the centre were linked and provided significant support for patients registered with the practice.

However there were areas of practice where the provider needs to make improvements.

Importantly the provider should

- Review how formal and informal multidisciplinary meetings are recorded.
- Review how learning from complaints can be shared more clearly with staff.
- Review processes for managing hospital discharge letters.
- Ensure copies of training certificates are held in staff files.

**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. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

**Are services effective?**

Outstanding

The practice is rated as outstanding for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

**Are services caring?**

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

**Are services responsive to people's needs?**

Outstanding

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

# Summary of findings

Patients told us it was generally easy to get an appointment and a named GP or a GP of choice, with continuity of care and urgent appointments available the same day. The practice had good very facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised.

**Are services well-led?**

**Outstanding** 

The practice is rated as outstanding for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

# Summary of findings

## The six population groups and what we found

We always inspect the quality of care for these six population groups.

### Older people

Outstanding 

The practice is rated as outstanding for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The healthy living centre ran a daily lunch club for older people, the practice referred patients with poor nutrition to the club and the lunch club brought patients to the practices attention if they had identified concerns. We saw practice staff visiting the lunch club to check those attending were well. The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. All had up to date care plans and these were shared with other providers such as the out of hour's service. All older patients discharged from hospital had a follow-up consultation where this was clinically advised.

### 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. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

### Families, children and young people

Outstanding 

The practice is rated as outstanding for the care of families, children and young people. Families and young patients were the highest proportion of the practice population with approximately 30% of patients being under 16 years. Immunisation rates for all standard childhood immunisations were above average for the CCG and up to 100% for many common illnesses such as polio and diphtheria and measles, mumps and rubella.

Many of the families arriving into the area arrived with existing difficulties and lack of resources. Urgent nurse clinics supported these patients; the practice was able to offer 15 minutes

appointments giving more time for patient education and support. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. The practice had a close working relationship with the local midwife service which provided six clinics a week. The midwives were viewed as an active member of the practices clinical team taking part in significant event audits and other meetings. The practice also had strong relationships with the Health Visiting team, Children's Social Care and Children's Centre which had a nursery provision on the premises.

One of the practice nurses had achieved the Queens Nursing award earlier this year for her work related to sexual health. They ran a specific clinic about sexual health each Wednesday for young people under the age of 21 years. To help address concerns about pregnancy in young people the nurse, who is the 'No Worries' advisor, visited a local school to advise on contraception and pregnancy avoidance. We saw evidence of signposting young people towards sexual health clinics and contraception advice in information around the practice. The practice also signposted younger patients to the 'No Worries' service which provided confidential, young people friendly services and advice on all aspects of growing up, relationships and health.

The co-location with the children's family service, 'Troubled Family' team, family nurse practitioners, health trainers and being part of the new Bournville One Police initiative ensured the practice had close links and information sharing with very local services. The Centre also operated a food bank to which the practice referred their most vulnerable families.

The midwives we spoke with told us about multidisciplinary team work involving practice staff and other organisations. Mother and baby and post natal clinics were provided each Tuesday afternoon with an immunisation clinic also available that afternoon. The mothers we spoke with spoke positively about the clinics and the support of the nurses and GPs involved in their maternity and post maternity care. The South Weston children's centre was based on the premises and the practice referred patients to the service.

**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

# Summary of findings

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.

**People whose circumstances may make them vulnerable**

Outstanding ☆

The practice is rated as outstanding 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. It had considered the needs of these patients and 100% of people with a learning disability were seen by clinical staff for a review. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. 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.

The practice had adopted the use of summary care records for their most vulnerable patients in this category. We saw the lead nurse had been proactive in promoting healthy lifestyles with patients. Information boards were maintained in prominent areas of the waiting areas, leaflets were available in the consulting rooms and advice offered was recorded in the patient's notes.

The practice was able to identify patients who may be living in vulnerable circumstances and had a system for flagging vulnerability in individual records. People were easily able to register with the practice, including those with "no fixed abode" care of the practice's address. People not registered at the practice are able to access appointments as temporary residents at the sit and wait clinic provided each day.

**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 majority of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

# Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including MIND and other local organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training on how to care for people with mental health needs and dementia.

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## What people who use the service say

We spoke with eight patients visiting the practice and three members of the patient participation group during our inspection. We received 11 comment cards from patients who visited the practice and saw the results of the most recent patient participation group survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice. 76% of patients described their overall experience of this surgery as good during the 2014 GP patient survey.

Comments made or written by the majority of patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving excellent care and treatment, about seeing a GP or nurse of their choice and about being treated with respect and consideration by all staff. Comments from other people visiting the healthy living centre also commented about the informative support they received with regard to their wellbeing. Comments about the reception team were equally positive.

We heard and saw the majority of patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. The most recent 2014 GP survey showed 73% of patients found it easy to get through to the practice and 85% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to make appointments, 73% describe their experience of making an appointment as good. However, patient attendance rates at appointments were often poor due to some patients chaotic lifestyle, over 90 appointments had been missed in the week prior to our inspection. The practice was aware of these issues and were working towards ways to improve access for example, by providing an improved telephone answering service at busy times which was supported by a duty GP.

Patients told us their privacy and dignity was respected at all times both during consultations and in the reception and waiting areas. They told us they found the reception area was generally private enough for most discussions they needed to make. The most recent 2014 GP survey showed 80% of patients said they found the receptionists at this practice helpful. Patients told us about GPs providing extra support to themselves and carers at times of difficulty and bereavement. Some patients had been attending the practice for over 10 years and told us about how the practice had evolved, how they were always treated well and how the most recent premises had improved access to treatments. The GP survey showed 74% of patients said the last GP they saw or spoke with was good at giving them enough time and 91% and 97% stated they had confidence and trust in the last GP or nurse they saw or with whom they spoke respectively.

Patients told us the practice always appeared clean and tidy and the practice had appropriate security measures at all times. Online repeat prescription facilities had been added to help patients access their medicines in a timely way. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets.

The practice had an active and fully engaged patient participation group (PPG) who met with practice staff regularly and helped make suggestions about improvements to the services offered by the practice. The last PPG report for March 2014 made several recommendations which they told us had been actioned. The groups representatives we spoke with also told us about the professionalism and responsiveness of the practice and the value they gained from the regular involvement of the Chief Executive and the practice manager in their meetings. All PPG members we spoke with told us about the high quality of patient care provided by the practice and about the dignity and respect shown by staff.

# Summary of findings

## Areas for improvement

**Action the service SHOULD take to improve**

- Review how formal and informal multidisciplinary meetings are recorded.
- Review how learning from complaints can be shared more clearly with staff.
- Review processes for managing hospital discharge letters.
- Ensure copies of training certificates are held in staff files.

## Outstanding practice

We saw areas of outstanding practice:

- To help address concerns about pregnancy in young people the nurse, who is also the 'No Worries' advisor, visited a local school to advise on contraception and pregnancy avoidance. The nurse also .ran a specific clinic about sexual health each Wednesday for young people under the age of 21 years. The co-location of the practice with the children's family services, 'Troubled Family' team, family nurse practitioners, health trainers and being part of the new Bournville One Police initiative ensures the practice is integrated into other services and information sharing took place with very local services. The Centre also operates a food bank to which the practice refers families.
- The practice experiences a very high appointment demand for conditions of low mood and anxiety. These demands are met by GPs and nurses working in partnership with other organisations the wellbeing worker employed in the centre. These support sessions played a key role in the emotional support of patients and helped re-able patients.
- The practice shared facilities with the Healthy Living Centre. Facilities included a church, a café, a library, a nursery, a 'shop' and a clothing bank as well as other community spaces. The clothing is brought to the shop and resold, it is also given away at the clothing bank to those in need. Funds raised go towards supporting a local food bank which currently supports approximately 70 of the practices patients. The 'shop', located adjacent to the practice waiting area, supplies fruit and vegetables which are not easily available locally. Patients are often encouraged to use this facility by the clinical team as part of healthy lifestyle advice. All aspects of the centre were linked and provided significant support for patients registered with the practice.

# Locality Health 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 and other specialists including, a practice manager and a practice nurse.

## Background to Locality Health Centre

Locality Health Centre, 68 Lonsdale Avenue, Weston-Super-Mare, S23 3SJ is located about a mile from the centre of Weston-Super-Mare. The premises are purpose built and are an integral part of the communities For All Healthy Living Company. The practice is a social enterprise organisation and forms part of the Community Interests Company which manages the location. Day to day management is overseen by a chief executive with clinical decision making being managed by the clinical team in conjunction with the practice manager and oversight from the board.

Locality Health Centre has approximately 5,100 patients registered with the practice with a catchment area of South Ward in Weston-Super-Mare and includes the Bournville estate. The former primary care trust had to establish a GP practice in the area as no local practices wanted to provide services. The practice became an integral part and founding partner of the For All Healthy Living Company which has a vision of an holistic approach to health and wellbeing.

For All Healthy Living Company is a community interest company (CIC), a model which aims to provide a benefit to the local community, where both staff and local people have representation on how the company functions. The Locality Health Centre CIC has a board which governs the company and includes a Chief Executive Officer (CEO), a Practice Manager, General Practitioners, two nurse representatives and a representative from the local community. In a CIC all staff share the same vision and values and work for the benefit of the company and the local community. This philosophy was very evident in the practice throughout our visit. This model is very different from a traditional medical practice where GP's form partnerships to run the practice.

To ensure all staff had a say in the business and its future the CIC held whole team meetings both in the evening and on Saturdays to discuss strategy and future plans. We were told these events had been well attended and well received by the staff and patient representative.

There are three salaried GPs employed by the practice. These are complimented by the use of named locum GPs who are covering a vacant salaried GP post. The GPs are supported by a team of clinical staff including a lead nurse, a nurse prescriber, three nurses, a recently appointed prescribing pharmacist and a health care assistant. The three GPs are female and the locums are male, the hours contracted by GPs are equal to 1.79 whole time equivalent employees. Additionally the nurses employed equal 4.51 whole time equivalent employees. Non-clinical staff included secretaries, IT staff, finance staff, support staff and a small management team including a practice manager. A Healthy Connections worker is also employed by the Healthy Living Centre and works with the practice providing a range of support for patients experiencing mental health problems. The centre is proactively managed by a chief executive who has day to day involvement with the practice.

The practice population is predominantly White British with an age distribution of male and female patients mainly in the working age population group. A significant

number of these patients are aged below the age of 20 years. The average male and female life expectancy for the practice is 75 and 81 years respectively, both are slightly below the national average. The patients come from a limited range of income categories with most patients being in the most deprived category. The area is recognised locally as being an island of deprivation surrounded by relative wealth and has over 60% social housing in the immediate area. It has significant mental health and drug and alcohol problems and a crime rate commensurately high. Literacy levels are particularly poor locally; the Healthy Living Centre helps support these patients through courses and advocacy services. At the end of the 20th and start of the 21st century, the Weston-Super-Mare saw a growth in residential rehabilitation treatment centers for people with drug and alcohol problems, with attendant crime and social problems. By 2009, it was home to around 11% of drug rehabilitation places in the UK. The practice is actively engaged with local agencies to support patients attending rehabilitation services.

Clinical consultations have increased from 29,000 per year in 2011/12 to over 40,000 for the year ending 2014/15. Patient turnover is approximately 22% currently. This is largely explained by the low level of resource patients arrive with when moving into or being placed in the area. Research has shown how the practice along with other community services helps re-resource patients and enables them to improve their personal circumstances and relocate.

Facilities within the Healthy Living Centre include a church, a café, a library, a nursery, a 'shop' and a clothing bank as well as other community spaces and the practice. The clothing brought to the shop is resold, unsold clothing is given away at the clothing bank. Funds raised go towards supporting a food local bank which currently supports approximately 70 of the practices patients. The 'shop', located adjacent to the practices waiting area, supplies fruit and vegetables which are not easily available locally. Patients are often encouraged to use this facility by the clinical team as part of healthy lifestyle advice. All aspects of the centre were linked and provided significant support to patients registered with the practice.

The practice has an Alternative Provider Medical Services (APMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, diabetes services, 'No Worries' young people's sexual health clinics and stretched targets for clinical care and patient access. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by BrisDoc and patients are directed to this service by the practice during out of hours. BrisDoc was also contracted to support the practice during normal working hours (until April 2015) to provide urgent home visits to patients requiring a GP visit when the practice's GPs are providing appointments to patients.

## 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. This 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.

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.

## How we carried out this inspection

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 are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people

# Detailed findings

- 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)

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the North Somerset Clinical Commissioning Group and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 9 April 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included two GPs and a former GP who chairs the executive board of the For All Healthy Living Company. We also spoke with four nurses, the prescribing pharmacist, the practice manager and four administrative and reception staff. We also spoke with a community nurse located in the practice. We spoke with eight patients visiting the practice during our inspection, four members of the patient participation group and received comment cards from a further 11 patients.

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, national patient safety alerts, information from other local organisations as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, when a vulnerable patient presented at the practice at different time in distress.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 12 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 12 months and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. Significant events were also a standing item on the practice clinical meeting agenda There was evidence the practice had learned from these events and that the findings were shared with relevant staff. However the complaints log lacked information to explain the detail behind the learning stated. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and told us they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. She showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example, a referral of a vulnerable adult to relevant safeguarding agencies. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken. These actions were also recorded in the significant event meeting minutes.

National patient safety alerts were disseminated by the practice manager and senior administrator to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

**Reliable safety systems and processes including safeguarding**

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training about safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff explained to us how they would recognise the signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead GP was and who to speak with in the practice if they had a safeguarding concern.

GPs were appropriately using the required codes on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to

make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans, those receiving palliative care and patients at high risk of hospital administration.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants and reception staff, had been trained to be a chaperone. One administrator would also act as a chaperone if nursing staff were not available. They had also undertaken in-house training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The lead GP attended child protection case conferences, reviews and serious case review meetings where appropriate. Reports were sent if staff were unable to attend. The nursing team followed up where children persistently failed to attend appointments for example, for childhood immunisations. We saw and heard about how the nurses frequently checked other areas of the Healthy Living Centre to see if these patients were using the facilities. If they were they invited them for an appointment there and then.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. We saw practice staff followed the policy.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. Clinical waste such as needles and blades were similarly safely disposed of.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. A prescribing pharmacist had been recently employed at the practice to help improve reviews of prescribing and to review patients taking multiple medicines. They also cascaded Medicines and Healthcare Products Regulatory Agency alerts to all clinical staff to ensure adherence and safe prescribing for patients.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Where the health care assistant administered vaccines such as influenza vaccinations these were carried out in conjunction with patient specific directions which were signed by the GP. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. There were two members of the nursing team who were non-medical prescribers; the lead nurse and a recently appointed advanced nurse prescriber. They received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which she prescribed.

All prescriptions were reviewed and signed by a GP or non-medical prescriber before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and these were tracked through the practice and kept securely at all times.

**Cleanliness and infection control**

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place for all areas of the premises as arranged by the chief executive and daily cleaning records were kept in all clinical areas. Similar arrangements were in place for patient areas such as toilets. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had identified the lead nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits annually and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

An up to date infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control

infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during intimate examinations. There was also a clearly displayed policy for needle stick injury and staff knew the procedure to follow in the event of such an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw records that confirmed the centre was carrying out these checks on the practices behalf in line with this policy to reduce the risk of infection to staff and patients.

**Equipment**

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer. The practice used single use items for patient examinations and these were disposed of in line with practice policies.

**Staffing and recruitment**

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at the staff files of five employees and found some information difficult to locate. The records we looked at contained generally evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). We did not see any copies of training certificates which the practice manager told us they did not routinely keep. They responded positively to this observation and put arrangements in place to ensure these were kept in future.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements. We observed staffing levels to be as described on the rota.

**Monitoring safety and responding to risk**

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice which reflected those used in managing the Healthy Living Centre. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was clearly displayed for staff to see. There was an identified health and safety representative who was in the process of reorganising how health and safety training was planned and provided.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at practice clinical meetings and within the various team meetings. For example, the lead nurse had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting

them to access emergency care and treatment and supporting them through the involvement of the wellbeing worker employed in the centre. The practice monitored repeat prescribing for people receiving medication for mental ill-health through the recently appointed prescribing pharmacist.

**Arrangements to deal with emergencies and major incidents**

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support with further training planned for 16 April 2015. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Signage in the practice and the centre clearly indicated where this equipment was located. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a recent medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines and equipment we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included utility failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of all utility companies to contact if the utilities failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Fire equipment such as extinguishers had been checked in March 2015 and the fire log held copies of all relevant service certificates.

Risks associated with service and staffing changes (both planned and unplanned) were included on the practice risk log. For example, managing the absence of a GP and the mitigating actions that had been put in place to such as the use of specific locum GPs to ensure continuity of treatment for patients.

Outstanding ☆

# Are services effective?

(for example, treatment is effective)

## Our findings

The patients we spoke with explained how the GPs and nurses supported them to manage their health conditions effectively. They told us about routine health checks, medicines reviews and the promotion of healthy living clinics which they attended and valued.

The close working relationships with other providers in the For All Healthy Living Centre and the proximity to each other enabled a collaborative approach in treating patients. We observed a sense of community and of working towards common goals which benefitted the patients in the practice.

**Effective needs assessment**

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw minutes of clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed and audited when appropriate.

The GPs told us they lead in specialist clinical areas such as rheumatoid arthritis, heart disease and asthma and the practice nurses supported this work through their own areas of expertise. This allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders and other conditions. Our review of the clinical meeting minutes confirmed that this happened.

The practice manager showed us data from the local CCG of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The prescribing pharmacist had also commenced a review of case notes for patients with comorbidities (one or more illnesses alongside a main illness) which resulted in all those reviewed receiving appropriate treatment and regular review. This was a continuing process. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks or sooner by their GP according to the patients' condition and needs.

National data showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers, they were referred and seen within two weeks. We saw minutes from clinical meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff for example, by making more nurse led appointments available.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice demonstrated a particularly tolerant attitude towards patients who had chaotic lifestyles and actively encouraged them to attend the practice.

**Management, monitoring and improving outcomes for people**

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and chief executive to support the practice to carry out clinical audits.

The practice showed us seven clinical audits that had been undertaken in the last two years, six of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of patients receiving anti-depressant medicines had identified where they had been prescribed them for more than two years and where a six monthly

review had taken place. Where they had not, recall appointments had been made and medicines were reviewed. Other examples included audits to confirm that the GPs who carried out lipid monitoring (Another word for "fat", lipids are easily stored in the body. They serve as a source of fuel and are an important constituent of the structure of cells). in relation to cardiovascular disease were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding patients diagnosed with chronic obstructive pulmonary disease (COPD) using triple therapy inhalers. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes. For example, one patient with Asthma and COPD with frequent use of standby (emergency) medicines more than monthly had stopped overusing, lost a lot of weight, felt a lot better and had not required the use of emergency services out of normal practice opening hours.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients newly diagnosed with diabetes, had a record of being referred to a structured education programme within nine months after entry on to the diabetes register, in the preceding year. The practice met all the minimum standards for QOF in asthma, chronic obstructive pulmonary disease (lung disease) and childhood immunisations.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement and planned to invigorate the audit programme in the coming year with support from the prescribing pharmacist

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it they outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. However minutes of these were not always recorded. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. All had up to date care plans and these were shared with other providers such as the out of hour's service. All older patients discharged from hospital had a follow-up consultation where this was clinically advised. Older patients who were prescribed multiple medicines were all in the process of receiving a structured annual medicines review.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were unique to other services in the area due to the population it served.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and

saw that all staff were up to date with or about to attend mandatory courses such as updates for annual basic life support. We noted a good skill mix among the GPs collectively having additional diplomas in sexual and reproductive medicine, children's health, obstetrics and diabetes. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, sexual health and drug misuse.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines, cervical cytology sexual health and diabetes. Those with extended roles for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X-ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a process for relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. However this process was not covered in a documented procedure which clearly stated when a GP was not required to view the letter. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified recently of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. We saw quality and outcomes framework (QOF) reports showing the practices performance with regard to hospital attendances and saw no concerns had been indicated.

The practice held multidisciplinary team meetings almost daily to discuss the needs of complex patients for example, those with drug and alcohol problems, mental health problems or children on the at risk register. These meetings involved district nurses, midwives, drug and alcohol workers, social workers and palliative care nurses. Decisions about care planning were documented on the patient record system and in shared care records. However, copies of minutes of the multidisciplinary team meetings were not formally held by the practice. Staff felt this system was useful as a forum and means of sharing important information.

**Information sharing**

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straight forward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient

record (EMIS) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

**Consent to care and treatment**

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff for example, 'any procedure which the patient considered to be substantial'. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it, and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick/Fraser competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions). A template was available for clinicians to use on the patient record system and we were shown copies of these

There was a practice policy for documenting consent for specific interventions. For example, contraception injections, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint and had received de-escalation training.

**Health promotion and prevention**

The practice had met with the Public Health team from the local authority and the North Somerset Clinical Commissioning Group (NSCCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs and nurses to use their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers. One patient we spoke with told us about the support they received to stop smoking during pregnancy. They told us they were proud of what they had achieved and were highly complementary about the support the nursing team provided.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 25% of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a record of all patients with a learning disability and the majority were offered an annual physical health check. Practice records showed most had received a check up in the last 12 months. The practice had also identified the smoking status of the majority of patients over the age of 16 and actively offered trained smoking advisor led smoking cessation clinics and one to one sessions to these

patients. There was evidence these were having some success as the number of patients who had stopped smoking in the last 12 months had risen by 62%, which was better than neighbouring practices. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 80.6%, which was in line with the average in the NSCCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and the practice audited patients who do not attend. There was also a named nurse responsible for following up patients who did not attend screening. Nurses also reminded patients about screening during other appointments to help encourage these checks.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The most recent Quality and Outcomes Framework (QOF) performance data for all immunisations was 100% for the majority of immunisations. This was above average for the NSCCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice provided annual reviews for patients diagnosed with various long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease. Data from the 2013/14 Quality and Outcomes Framework (QOF) showed 89% of patients diagnosed with diabetes received an annual influenza vaccination. The practice had adopted the use of summary care records for their most vulnerable patients in this category. We saw the lead nurse had been proactive in promoting healthy lifestyles with patients. Information boards were maintained in prominent areas of the waiting areas, leaflets were available in the consulting rooms and advice offered was recorded in the patient's notes.

All staff actively encouraged self-care, education and management. The lead clinical nurse had organised a range of information to promote healthy lifestyles. Clinics were available to provide smoking cessation and nurses referred patients to weight management programmes where appropriate. We heard from patients about their achievements at these clinics, for example, a patient who had successfully given up smoking. The practice worked hard to maximise ease of access to patients by encouraging other services to operate from the centre, these currently include, pulmonary rehabilitation, retinal screening, and a heart failure nurse service. Current QOF indicators were positive for these conditions with the practice managing to meet most of their stretch contract key performance indicator targets for these areas.

Housebound patients were supported to manage their health by the community matron with whom meetings were held. The practice also arranged joint visits to these patients as appropriate.

We saw evidence of signposting young people towards sexual health clinics and contraception advice in information available around the practice. The practice also signposted younger patients to the 'No Worries' service which provided confidential, young people friendly services and advice about all aspects of growing up, relationships and health.

One of the practice nurses had achieved the Queens Nursing award earlier this year for her work related to sexual health. They ran a specific clinic about sexual health each Wednesday for young people under the age of 21 years; this clinic was also available to young people who were not registered with the practice. The nurse spent time speaking with young patients about relationships, consent, the risks involved and provided advice about the forms of contraception available. They also offered screening for sexually transmitted diseases. To help address local concerns about pregnancy in young people the nurse, who is also the 'No Worries' advisor, visited a local school between 3:00 pm and 4:00 pm to advise on contraception. Anecdotal information showed pregnancy rates had fallen slightly due to this collaborative working.

The practice held a register of patients whose circumstances may make them vulnerable for example, those who may be homeless, drug and alcohol dependent or those with diagnosed learning disabilities. We were provided with evidence of multidisciplinary team working and case management of vulnerable patients and saw the practice provided drug project worker led clinics each week. Additionally we saw evidence of signposting patients to various support groups and third sector organisations such as, local specialist drug and alcohol services, Addiction recovery agency and Alcoholics Anonymous.

There were a significant number of patients who used or had used drugs in the practice area and there were two

Outstanding ☆

# Are services effective?

## (for example, treatment is effective)

regular weekly clinics for patients provided by the local 'Addaction' support agency. This agency had recently taken over the contract for providing alcohol support and would be providing more services in the centre in the near future to the benefit of the practices patients. The practice has a very close working relationship with Broadway Lodge, one of the largest residential treatment centres for alcohol and drug addiction, eating disorders, co-dependency and recovery in the country. People receiving treatment there were registered as temporary patients and were supported by the practice. Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child and Adolescent Mental Health Services (CAMHS) and adult mental health services. The practice carried out joint patient consultations with local mental health teams where relevant. This helped ensure greater continuity of treatment for the patient and improved information sharing for the professionals involved. For example, in the types and choices of treatment available to the patients.

Good

# Are services caring?

## Our findings

The ethos of the centre and the practice was to support patients and the broader community to become better resourced and more resilient. Facilities within the Healthy Living Centre include a church, a café, a library, a nursery, a lunch club, a 'shop' and a clothing bank as well as other community spaces. The clothing brought to the shop is resold or if not sold it is given away at the clothing bank. Funds raised went towards supporting a food local bank which currently supports approximately 70 of the practices patients.

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2014 and information from the practice's patient participation group (PPG) as well as information available from the NHS Choices website. The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated positively for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 81% of practice respondents saying the GP was good at listening to them and 74% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive but there were no common themes to these. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. A system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this and the de-escalation training they received had helped them diffuse potentially difficult situations.

Patients whose circumstances may make them vulnerable and those who experienced poor mental health were able to access the practice without fear of stigma or prejudice. Staff treated all patients from these groups in a sensitive manner. Equality and diversity and managing challenging behaviour training had been made available to staff and helped support staff to deal sympathetically with all groups of people. An interpreting service was available in the practice and was used by staff to help understand patient's needs.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed the culture in the practice was for patients to be cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate. The practice demonstrated a particularly tolerant attitude towards patients who had chaotic lifestyles and actively encouraged them to attend the practice.

Good

# Are services caring?

**Care planning and involvement in decisions about care and treatment**

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 68% of practice respondents said the GP involved them in care decisions and 76% felt the GP was good at explaining treatment and results. Both these results were approximately average for the North Somerset Clinical Commissioning Group area (NSCCG). The results from the practice's friends and family survey showed that 85% of patients said they received a good service at the practice.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and 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 they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

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 area and on the practices website informing patents this service was available.

Children and young people were treated in an age-appropriate way by staff who recognised them as individuals. Their preferences were considered and the practice used young people friendly approaches. There was strong evidence of this approach from the nurse providing sexual health advice to younger patients and from the patients who had appointments with her.

One of the nurses with an interest for caring for younger patients ran a specific clinic about sexual health each Wednesday for young people under the age of 21 years. The clinic was also available to young people who were not registered with the practice. The nurse spent time speaking with young patients about relationships, consent, the risks involved and provided advice about the forms of contraception available. They also offered screening for sexually transmitted diseases. To help address local concerns about pregnancy in young people the nurse, who is also the 'No Worries' advisor, visited a local school between 3:00 pm and 4:00 pm to advise on contraception. This caring approach had resulted in pregnancy rates having fallen slightly due to this collaborative working.

**Patient/carer support to cope emotionally with care and treatment**

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 95% of patients said they had been treated with care and concern by the last nurse who saw them. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

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 or by giving them advice on how to find a support service. The wellbeing worker employed in the centre played a key role in the emotional support of patients, and their integration with the practice ensured patients were supported to cope emotionally with their care and treatment.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and North Somerset Clinical Commissioning Group (NSCCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. These included; Ensuring an integrated health and social care, providing the best possible health care for the patients, reducing health inequalities, improving patient care and motivating member practices to deliver safe care and evidence based practice

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included, improving the appointment system, improving continuity of treatment, reducing waiting times, improving patient information and increasing privacy at the reception desk. All but the last point had currently been achieved with reception desk improvements now having had funds identified; work was due to start shortly.

Patients were able to request repeat prescriptions in a number of ways including online, in person, and via a repeat prescription box in the surgery. Prescriptions were available within 48 hours but in an emergency they could be provided sooner. This was confirmed by the patients we spoke with.

We were told the practice had found it very difficult to recruit to vacant GP posts within the practice despite numerous attempts at recruiting. At a board session of the community interest company conscious decisions were made to change the structure of the clinical team, by enlarging the nursing team. This enabled the nursing team to take on some of the roles traditionally performed by a GP. This action was supplemented by also employing a clinical pharmacist to focus on complex medicine reviews.

The nursing team comprised of a lead nurse/advanced nurse practitioner (ANP), and another ANP both of whom were non-medical prescriber's. In addition the practice had nurses who specialised in long term conditions including diabetes and chronic obstructive pulmonary disease (COPD),a nurse who specialised in sexual health, treatment room nurses and health care assistants completed the team. This team was observed to be outstanding in its motivation and enthusiasm to develop treatment and support to suit the needs of their patients and improve the service. The two ANPs saw patients with complex urgent needs and specialised in specific diseases in Long Term conditions. They also took on GP's tasks such as writing reports and doing the majority of the home visits within the practice. All the nursing team fitted in urgent patient appointments during their day and took time with patients to deliver health promotion and advice. The nurses supported each other as necessary to ensure the best possible service is given to patients. It was evident from our interviews with the nursing team that the whole team were passionate about their work and where they worked.

Nursing staff had been trained for chronic disease identification and for the management and long term conditions. The practice showed us information to confirm 99% of patients' records were summarised and 92% of new patient notes were summarised within 8 weeks. The practice offered a range of long term clinic appointments at various times throughout the day to try to encourage patient to engage with and manage their long term health condition. Clinical staff followed and promoted National Institute for Health and Care Excellence (NICE) guidelines in support of these patients through a range of clinics. These clinics were supported by referrals to other activities arranged by the For All Healthy Living Centre.

Families and young patients were the highest proportion of the practice population with 30% of patients being under 16 years. Many of the families arriving into the area arrive with existing difficulties and lack of resources. There were many other facilities in the centre used by families which enabled the nurses to engage informally with families. They were particularly good at being persistent in getting young children to attend for vaccinations. Immunisation rates for all standard childhood immunisations were above average for the CCG and up to 100% for many common illnesses such as polio and diphtheria and measles, mumps and rubella. Urgent nurse clinics supported these patients; the practice was able to offer 15 minutes appointments giving

more time for patient education and support. There were a number of children on Child Protection Plans and the Children in Need register. There was a robust system of alerts on patient records where concerns were indicated. The practice had a close working relationship with the local midwife service which provides six clinics a week. The midwives were viewed as an active member of the practices clinical team taking part in significant event audits and other meetings. The practice had strong relationships with the Health Visiting team, Children's Social Care and Children's Centre which had a nursery provision on the premises.

The co-location with the children's family service, 'Troubled Family' team, family nurse practitioners, health trainers and being part of the new Bournville One Police initiative ensured the practice had close links and information sharing with very local services. The Centre also operated a food bank to which the practice referred their most vulnerable families.

The midwives we spoke with told us about multidisciplinary team work involving practice staff and other organisations. Mother and baby and post natal clinics were provided each Tuesday afternoon with an immunisation clinic provided by the practice also available that afternoon. The mothers we spoke with spoke positively about the clinics and the support of the nurses and GPs involved in their maternity and post maternity care. The South Weston children's centre was based in the premises and the practice referred patients to the service. The service provided a range of services, support and advice to parents of children (aged 0 to 5 years) and their families. Regular activities included a Health Visitor drop-in session, stay and play sessions, ante- and postnatal groups, breast feeding support and information about childcare, adult learning and employment.

The practice held regular meetings with the hospice nurse and their lead nurse had weekly updates with community matron and district nurse. These were followed up by records being entered in the patients' notes and information was shared with relevant clinicians. The healthy living centre ran a daily lunch club for older people, the practice referred patients with poor nutrition to the club and the lunch club brought patients to the practices attention if they had identified concerns. We saw practice staff visiting the lunch club to check those attending were well.

**Tackling inequity and promoting equality**

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, vulnerable patients, the unemployed and patients with drug and alcohol problems.

The practice had access to online and telephone translation services and a GP who spoke two languages.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been purpose built to meet the needs of patients with disabilities There were parking spaces for patients with disabilities and level access into the practice. Automatic opening doors assisted access into the building and there was sufficient space for wheelchair users and parents with pushchairs to manoeuvre safely. There were accessible toilets and baby changing facilities. All consulting and treatment rooms had level access and were only a short distance from the waiting area. A privately run pharmacy was located across the road from the practice and enabled patients to access prescribed medicines easily.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

The practice was able to identify patients who may be living in vulnerable circumstances and had a system for flagging vulnerability in individual records. People were easily able to register with the practice, including those with "no fixed abode" care of the practice's address. People not registered at the practice are able to access appointments as temporary residents at the sit and wait clinic provided each day. There was a system to communicate with patients of "no fixed abode, this was usually done by telephoning them.

A new permanent site for the Gypsy, traveller and Romany community was just about to be completed in the practices catchment area. The practice had been involved in the

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

North Somerset Strategy and had been having meetings with the organisation who would be running the site, to plan and understand the potential health needs of this group of people.

The For All Healthy Living Centre with a Lottery Grant had piloted employing a Wellbeing Worker who had augmented the IAPT service by being able to offer a more local, flexible and solution focussed approach to patient care and support. This pilot worked very closely with the practice and had carried out joint patient visits with members of the clinical team to support patients with on-going conditions who also had mental health issues. The practice is currently investigating a social prescribing role based in the practice, with NHS England.

**Access to the service**

All patients including those of working age had access to appointments were available from 8:30 am to 5:30 pm on weekdays. Clinics and surgeries were by appointment only and were provided from 8.30am to 12 noon in the morning and 2.00pm to 5.30pm in the afternoon. Urgent medical needs requiring on the day appointments were offered at a 'sit and wait clinic' which starts at 11.20 am. A call back list was also provided where patients would be contacted by a clinician who discussed the patient's condition and decide the best course of action for example, routine or immediate appointments, self-treatment or a home visit. Additionally the practice provided appointments on one Saturday morning each month between 9:00 am and 11:00 am for pre-booked appointments. A range of additional in-house services including, phlebotomy (blood tests), spirometry (a test that can help diagnose various lung conditions), international normalized ratio (INR) blood tests monitoring and NHS health checks were provided.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Longer appointments were also available for patients who needed them and for those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to those patients who needed one.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment for their unwell child and were seen by a GP within two hours of calling the practice.

Appointments were available outside of school hours for children and young people. The premises were suitable for children and young people and joint working with sexual health clinics was routinely provided.

An online booking system was available and easy to use. The practice used telephone appointment reminders for patients known to be poor attenders and provided telephone consultations where appropriate.

People whose circumstances may make them vulnerable were supported by partnership working to understand and treat the needs of the most vulnerable in the practice population. The practice linked to the local housing association, provided longer appointments for those that need them. There were a range of flexible services and appointments including for example, avoiding booking appointments at busy times for people who may find this stressful.

**Listening and learning from concerns and complaints**

The practice had a 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 both on the practice website and on waiting area notice boards, information was also in the practice brochure. Patients we spoke with

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

were not aware of the process to follow if they wished to make a complaint but told us they felt their complaint would be listened to. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, with openness and transparency when dealing with the compliant.

The practice reviewed complaints routinely to detect themes or trends. We looked at the minutes of the last time complaints were discussed, no themes had been identified. The focus was on the complaints received and not common themes. Actions from lessons learned from individual complaints were recorded as having been discussed on the complaints log. However the learning section of the complaints log did not always make it clear about the detail of the learning gained or the detail of the actions taken.

# Are services well-led?

Outstanding ☆

(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. We found details of the vision and practice values were part of the practice's strategy and five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included; providing high quality primary care treatment, prevention of disease by promoting healthy living and wellbeing, involving patients, Working in partnership with other professionals, ensuring staff have the right skills and training to carry out their duties, promoting and sharing learning, seeking continual improvement, providing a safe and effective services and environment and acting with integrity.

We spoke with six members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. They explained this vision sat alongside the practice ethos which they were committed to and which formed part of their induction pack. The ethos stated. "The Centre aims to provide a safe a and welcoming place for local people to meet, engage with activities and services and take an active part in what happens in the centre. Partnership with the local community is a key value of the centre. We actively seek the views and opinions of local people in trying to improve the services offered and build a more sustainable community". Our observations confirmed this approach was applied by staff.

The most recent statistics provided by the practice indicated the local area had the highest prevalence of depression in North Somerset and the second highest prevalence of depression in the former South West Strategic Health Authority. The practice experienced a very high appointment demand for conditions of low mood and anxiety. These demands were met by GPs and nurses working with the primary care liaison service, the 'improving access to psychological therapies' (IAPT) service and 'Positive Steps' wellbeing service, to offer support sessions in the centre for patients.

**Governance arrangements**

The practice held monthly governance meetings where performance, quality and risks had been discussed.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 16 of these policies and procedures and most staff had completed a cover sheet to confirm that they had read the policy and when. All 16 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the GP was the member of staff with lead responsibility for safeguarding. We spoke with six members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, an audit of patients receiving anti-depressant medicines had identified where they had been prescribed them for more than two years and where a six monthly review had taken place. Where they had not, recall appointments had been made and medicines were reviewed.

The practice had arrangements for identifying, recording and managing risks. The practice manager made risk assessments available to us which addressed a wide range of potential issues. For example, ensuring the premises maintenance was managed appropriately. We saw the risks were discussed at relevant staff and health centre meetings and were updated. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, we saw a prescribing pharmacist had been employed to work with the practice to review prescribing so that medicines were prescribed therapeutically and risk to patients was minimised.

**Leadership, openness and transparency**

# Are services well-led?

Outstanding ☆

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

The board of the community interest company played a major part in the functioning of the practice. They were accessible through the membership of the GPs and nurses and responded positively to the changing needs of the practice.

We saw from minutes that management team meetings were held regularly, at least monthly. These meetings involved GPs, the lead nurse, the practice manager and chief executive. Staff who attended these meetings told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. GPs held clinical meetings and ensured they were informed of the most up to date clinical information. Similar meetings were held for the nursing staff.

Administrative 'office' meetings were also held regularly to plan and deliver the practices services and to reflect on the positive work done by this team of staff. For example, implementing a new 'sit and wait' clinic. Other subjects discussed included, staff absences, new staff appointments and processes for summoning ambulances. The minutes showed these meetings were well attended.

Overall the staff we met spoke positively about the leadership within the practice and with the board of directors and how they were accessible, open and transparent in the way they supported all employees in the practice. We saw that staff with lead responsibility within the practice took their roles seriously and ensured staff were kept informed of improvements in the way they worked. We observed the office functions within the practice were well led by an engaged management team who communicated effectively with staff at all levels.

Leadership was a shared responsibility across the practice with staff taking innovative approaches to ensure better outcomes for patients. For example, the nursing team followed up where children persistently failed to attend appointments such as, for childhood immunisations. We saw and heard about how the nurses frequently checked other areas of the Healthy Living Centre to see if these patients were using the facilities. If they were they invited them for an appointment there and then, thereby helping patients to receive the treatment they needed such as vaccinations.

**Practice seeks and acts on feedback from its patients, the public and staff**

The practice had gathered feedback from patients through for example, patient surveys, the NHS Choices website, comment cards, the 'Friends and Families' questionnaire and complaints received as well as the patient participation group. We looked at the results of the annual patient survey and 87% of patients were able to get an appointment to see or speak to someone the last time they tried. However, 73% said they found easy to get through to this surgery by phone. We saw as a result of this the practice had introduced telephone consultation appointments and were looking into further ways of improving access.

The practice had an active patient participation group (PPG) which had remained the same size for the last couple of years. The PPG included representatives from various population groups including all but the youngest patients. The PPG had carried out half yearly surveys and met approximately every quarter. The practice manager shared with us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. The PPG members we spoke with during the inspection were highly complementary about the treatment provided in the practice and by the leadership shown by the practice manager and Chief executive. They told us they responded positively to suggestions for improvement and had seen improvements. For example, and improved prescription service, online services and more health and wellness clinics.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss concerns or issues with colleagues and the management team. We heard from staff how they had requested additional training about safeguarding vulnerable patients and this had been provided. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

**Management lead through learning and improvement**

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw regular

# Are services well-led?

Outstanding ☆

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

appraisals had taken place which included a personal development plan. The practice recognised there had been a lack of appraisals in the last six months and had instigated a plan to reinvigorate them. Staff told us that the practice was very supportive of training and that they had opportunities to improve their learning.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. A similar approach had taken place for complaints within relevant teams. The chief executive and the board used information from the quality and outcomes framework (QOF) and the Hospital Episode Statistics (HES). (HES is a data warehouse containing details of all admissions, outpatient appointments and A&E attendances at NHS hospitals in England) to inform service improvements.