Dr Nelson & Partners

Quality Report

Harley House Surgery
2 Irnham Road
Minehead
Somerset
TA24 5DL
Tel: 01643 703441
Website: www.harleyhousesurgery.co.uk

Date of inspection visit: 19 November 2014
Date of publication: 31/03/2015

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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Harley House Surgery on the 19 November 2014. During the inspection we gathered information from a variety of sources. For example, we spoke with patients, members of the patient forum, interviewed staff of all levels and also checked the right systems and processes were in place.

Overall the practice is rated as requires improvement. This was because we found the practice required improvement in providing safe and well led services to patients. We found they had good practice for providing responsive, effective and caring services. The concerns found in safe and well led effected everyone using the practice which meant even though we found the practice was providing some good practice for all the population groups this made them requiring improvement overall.

Our key findings were as follows:

- The practice was accessible to patients who needed to be seen the same day. The practice had a triage and 'sit and wait' system used each day to enable any patient to be seen and patients were prioritised by appropriate staff.
- There was a high satisfaction rate from the patients in the practice; patients felt they were treated with respect and kindness from all staff the majority of the time.

We saw several areas of outstanding practice including:

- The practice provides care and treatment to approximately 100 patients who reside in a life skills college and working hotel for people with a learning disability. The practice had received an award from the Fox's academy community award 2014 for their support and patience in enabling learners to work towards independence. Students had also been invited and attended the patient participation group.
- The nurse practitioner had provided additional training for the local services. For example, they had

Summary of findings

provided training for staff to administer ear and eye drops for the life skills college. They had also provided additional tissue viability training for the nurses at one of the local nursing homes.

- The practice had held an open day in the last year to promote awareness of what the practice could offer in regards to health promotion, such as smoking cessation and local support services. It was also an opportunity to encourage patients to sign up for online appointments. Patients could also get their blood pressure and cholesterol checked by the nursing team. We were told 120 patients and other members of the community attended this open day.

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

Importantly, the provider must:

- Ensure patient records are secure at all times to ensure patient confidentiality.
- Ensure there are suitable emergency medicines and appropriate medicines in home visit bags to deal with a medical emergency and maintain risk assessments for these medicines as outlined in current researched guidance.
- Ensure clinical audits follow a clear purpose including completing cycles to ensure procedures were embedded and shared learning within relevant members of the team to maintain a consistent approach in treating patients.
- Ensure policies and procedures reflect current local or national guidelines, inform staff of their responsibilities in current practice procedures and are reviewed at appropriate timescales.

In addition the provider should:

- Undertake risk assessments for employee roles which do not require a criminal background check and who may be required to act as a chaperone.
- Ensure GPs follow current guidance when providing results of anticoagulant results to its patients in nursing and residential homes.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services as there are areas where it should make improvements. Although risks to patients were assessed, the systems and processes to address these risks were not implemented consistently throughout the team to ensure patients were kept safe. Reception staff who carried out chaperoning duties did not have an appropriate criminal background check. The practice had not appropriately risk assessed their emergency medicines and home visit bags to ensure they could deal with all potential medical emergencies. Patient records were not held securely enough to keep ensure patient confidentiality was upheld at all times.

Staff understood their responsibilities to raise concerns, and to report incidents and near misses. There were regular significant event meetings held with all staff, to ensure all staff learned from other staffs experiences.

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance such as from the National Institute for Health and Care Excellence. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included promoting good health. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. National data showed patients rated the practice higher than others for several aspects of care and lower than average in other aspects. The majority of 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 saw staff treated patients with kindness and respect, and maintained confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. They reviewed the needs of its local population and engaged with the NHS England local area team and Somerset Clinical Commissioning

Summary of findings

Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.

The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. There was evidence of learning from complaints.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had set aims and objectives but did not have a formal business plan. Discussions had been held about changes in the future, such as the potential loss of partners due to retirement, which had been discussed in business partner meetings.

The practice prided itself on its flat hierarchy to ensure staff were comfortable in raising concerns or issues with management. Staff were aware of who had lead roles and heard of examples of when they had been approached with issues. The practice proactively sought feedback from patients and had an active patient participation group (PPG).

The arrangements for governance do not always operate effectively. We saw some evidence audit was driving improvement in performance to improve patient outcomes but this was not a consistent approach amongst all staff. The practice had a number of policies and procedures to govern activity, but some of these were overdue for review and did not reflect current guidelines or legislation. Opportunities to learn from each other were often missed amongst some staff, for example, through learning from results of clinical audits.

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

Requires improvement

The practice is rated as requires improvement for the care of older patients. The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safety and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice offered proactive, personalised care to meet the needs of the older patients in its population. The nurse practitioner had the responsibility to visit patients who were housebound or resided in a residential or nursing home. They ensured they had advanced care plans and appropriate health checks. The practice was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs. The practice had a low threshold for prescribing just in case medicines for patients with an end of life plan because of poor access to local pharmacies and the locality of the ambulance service.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of patients with long-term conditions. The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safety and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

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

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young patients. The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safety and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

Summary of findings

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. For example, children and young patients who had a high number of A&E attendances. The health visitor was based in the practice which improved communication and information sharing. Immunisation rates were either higher than average, average or just below average for standard childhood immunisations.

Appointments were available outside of school hours and the premises were suitable for children and babies. The practice intended to develop working with the local school and further promoting health care for school children. The community midwife had access to patient records and so could be updated with the patients' medical history promptly.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age patients (including those recently retired and students). The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safety and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had tried extended hours on both weekday evenings and Saturdays. They found weekday evenings had been more popular and have continued with these extended hours. The practice was proactive in offering online services, such as repeat prescriptions and making an appointment 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

Requires improvement

The practice is rated as requires improvement for the care of patients whose circumstances may make them vulnerable. The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safety and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those

with a learning disability. The practice had carried out annual health checks for patients with a learning disability and 100% of these patients had received a follow-up. They offered longer appointments for patients with a learning disability.

The practice provides care and treatment to approximately 100 patients who reside in a life skills college and a working hotel for people with a learning disability. The practice had received an award from the Fox's academy community award 2014 for their support and patience in enabling learners to work towards independence. We received positive comments from a member of staff at the college who was a member of the patient participation group. They told us that students saw the same GP, the service was easy to access and they were provided with prompt appointments when required. Students had also been invited and had attended the patient participation group. All new patients with a learning disability were invited to the practice to see the facilities and meet practice staff to support them in adjusting to the practice.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. They had told vulnerable patients about how to access various support groups and voluntary organisations. We received a comment from a mental health recovery worker who wanted to commend the practice receptionists on how they went over and above to help assist a homeless person they were supporting and the positive effect it had for the person.

The practice often saw patients who were visiting the area on holiday, mainly during the summer months.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing and documenting safeguarding concerns.

People experiencing poor mental health (including people with dementia)

Requires improvement

The practice is rated as requires improvement for the care of patients experiencing poor mental health (including patients with a diagnosis of dementia). The practice was rated as good for effective, caring and responsive overall and this includes for this population group. The practice was rated as requires improvement for safety and well-led. The concerns which led to these ratings apply to everyone using the practice, including this population group.

The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with a form of dementia. The practice carried out advance care planning for patients living with a diagnosis of dementia.

Summary of findings

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations including local singing for patients with a form of dementia. GPs followed up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. The practice had good communication with the community psychiatric nurse who was based at the local community hospital.

Summary of findings

What people who use the service say

During our inspection we met with two members of the practice participation group (PPG). There were currently 12 members of the PPG. They told us the practice was committed to improving patient care and included the PPG in the decision making when changes were planned. The practice had representatives from the local college who supported patients with a learning disability who attend PPG discussions. We received very positive feedback from a staff member about the care and treatment provided by the practice.

Prior to our inspection we asked patients to complete our comment cards to tell us about the service received. We received 21 comment cards, which provided us with a very positive experience of the care patients received at the practice. Patients held the nurse practitioner in high regard particularly around managing long term conditions; and of the compassion provided to patients when they were required emotional support. During and after our inspection we spoke with seven patients, five patients were mainly very complimentary about the practice.

As part of the GPs revalidation in line with their General Medical Council registration to practice, GPs should receive a minimum of 34 patient views about the care and treatment they have provided. We know from conversations with the GPs that not all GPs had been revalidated yet. The PPG and the practice had decided that due to patients completing a number of surveys they would use this survey as part of their analysis of the service alongside the friends and family test and the results from the national GP patient survey.

The practice had completed the friends and family test throughout October 2014. This was a new national initiative for GP practices to ask their patients would they recommend the service to their friends and family. We saw 98% of the 298 patients surveyed had responded saying they would recommend the practice to friends and family. The main reasons for their decision was 64% confidence in the GP or nurse and 22% support by practice staff.

Prior to our inspection we reviewed other sources which reported patient experience with the service provided. This included NHS choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been one negative comment made about the practice in the last year. The patient had decided to leave the practice due to the receptionist's attitude in booking an urgent appointment for their young son. The practice informed us this had now been resolved with the patient directly.

We reviewed the national GP patient survey taken from patients from the periods of July to September 2013 and January to March 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 112 patients had completed the surveys from the 251 sent. We saw 97% of patients surveyed said their overall experience of the practice was good with 98% of patients saying their last appointment was convenient. There were a number of areas where patient satisfaction was less than the local CCG area, including 80% of patients saying GPs were good at explaining tests and treatments and 86% saying their GP treated them with care and concern.

Areas for improvement

Action the service MUST take to improve

- Ensure patient records are secure at all times to ensure patient confidentiality.
- Ensure there are suitable emergency medicines and appropriate medicines in home visit bags to deal with a medical emergency and maintain risk assessments for these medicines as outlined in current researched guidance.

Summary of findings

- Ensure clinical audits follow a clear purpose including completing cycles to ensure procedures were embedded and shared learning within relevant members of the team to maintain a consistent approach in treating patients.
- Ensure policies and procedures reflect current local or national guidelines, inform staff of their responsibilities in current practice procedures and are reviewed at appropriate timescales.

Action the service SHOULD take to improve

- Undertake risk assessments for employee roles which do not require a criminal background check and who may be required to act as a chaperone.
- Ensure GPs follow current guidance when providing results of anticoagulant results to its patients in nursing and residential homes.

Outstanding practice

The practice provides care and treatment to approximately 100 patients who reside in a life skills college and working hotel for people with a learning disability. The practice had received an award from the Fox's academy community award 2014 for their support and patience in enabling learners work towards independence. We received positive comments from a member of staff at the college who also participates in the patient participation group. They told us their students saw the same GP, the service was easy to access and they were provided with prompt appointments when required. Students were invited and attended the patient participation group.

The nurse practitioner had provided additional training for the local services. For example, they had provided training for staff to administer ear and eye drops for the life skills college. They had also provided additional tissue viability training for the nurses at one of the nursing homes.

The practice had held an open day to promote awareness of what the practice could offer regarding health promotion, such as smoking cessation and local support services. It was also an opportunity to encourage patients to sign up for online appointments. Patients could also get there blood pressure and cholesterol checked by the nursing team. We were told 120 patients and other members of the community attended this open day.

Dr Nelson & Partners

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 who has a number of years' experience practising in general practice. We also took a practice manager who has a range of experience in managing a range GP practices.

Background to Dr Nelson & Partners

We inspected the location of Dr Nelson and partners, Harley House Surgery, 2 Irnham Road, Minehead, Somerset, TA24 5DL, where all registered regulated activities were carried out.

The practice serves approximately 7,000 patients and covers the main area of Minehead in Somerset and a number of villages in the surrounding area. There are a small proportion of patients registered who live in Devon which is out of the normal catchment area for this practice.

The national general practice profile shows the practice has a large demographic of patients over the age of 65 years old at 52.4%. This is over the England and Somerset Clinical Commissioning Group (CCG) average, particularly between the ages of 65 to 69 years old and over 85 year olds. The practice is under the national and CCG average for patients under 19 year olds at 27.3%. The practice patient base is in the middle range for deprivation in the local area.

There were six GP partners, four male and two female, they work hours equivalent to four and a third full time GPs. The practice is a training practice for doctors requiring training in a general practice.

The practice was a GP training practice and had been for 19 years. Two GPs are educational supervisors, each holds an additional higher educational qualification; one is a training programme director, while the other supports GPs in difficulty. Another GP is a clinical supervisor and advises the Lord Chancellor's office on benefit appeals, and is the West Somerset Local Medical Committee member. Two GPs are appraisers for NHS England; one of them is also vice–chairman of the local GP federation.

The practice has a nurse practitioner, who works four days a week. A nurse practitioner is an advanced practice registered nurse, who has completed an additional three years training to enable them to have an increased knowledge base, clinical expertise and decision making skills. The nurse practitioner at this practice has also trained to prescribe medicines for a number of additional treatments, such as for urinary tract infections. This enables the GPs to see patients with more complex needs.

In addition to the nurse practitioner the nursing team consisted of two female and one male practice nurse, two female health care assistants and two phlebotomists.

The practice has a General Medical Service contract with NHS England. The practice referred their patients to NHS 111 for out of hours services to deal with urgent needs when the practice was closed.

The CQC intelligent monitoring data placed the practice in band one. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

Detailed findings

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.

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 patient's needs?
- Is it well-led?

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

- Older patients
- Patients with long-term conditions
- Families, children and young patients
- Working age patients (including those recently retired and students)
- Patients whose circumstances may make them vulnerable
- Patients experiencing poor mental health (including patients with a form of dementia)

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with the Somerset Clinical Commissioning Group, NHS England local area team, Somerset Local Medical Council and the local area Healthwatch. We carried out an announced visit on the 19 November 2014. During our visit we spoke with a range of practice staff including the practice manager, four out of the six GP partners, the nurse practitioner; two members of the nursing team including a health care assistant, two receptionists, a medical secretary and a prescriptions clerk. We also spoke with the managers of two nursing homes, a residential home for older people and a representative for a local college that supported patients with a learning disability.

We spoke with eight patients including two patients who were members of the patient participation group and reviewed 22 comment cards where patients shared their views and experiences of the service prior to our inspection.

Requires improvement

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. We saw staff had reported incidents such as safeguarding or significant events. Staff we spoke with were aware of their responsibilities regarding how to raise concerns, and knew how to report incidents. For example, one of the nursing staff told us of a medical emergency that had occurred in the waiting room. They told us the staffing team discussed this incident after it had occurred and decided to feedback back to the other service involved as part of their learning. Practice staff told us there was an open environment for staff to report their concerns to the practice manager or the GP partners.

We reviewed the significant events and complaints over the last year. We saw within practice meeting minutes these incidents had been discussed and showed how the practice could improve service provision to prevent recurrence.

The partners in the practice received regular clinical and best practice updates from organisations such as National Institute of Health and Clinical Excellence, NHS England and other sources. These updates were disseminated to appropriate staff via the practice manager. The partners told us these were discussed informally and had their own protected time to review these but there was no formal discussion with all GP partners to enable a consistent approach to treatment. Nursing staff told us they discussed national guideline updates at their nurse team meeting and updated their protocols to reflect this guidance. The practice stated they continually followed the changes required by the Quality and Outcomes Framework system.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. However, did not always inform other services involved following the practice review of the incident and learning that could be made by others. We saw there had been six significant events that had occurred since January 2014. Significant events were discussed during the quarterly 'all staff' meetings. Staff, including receptionists, administrators and nursing staff felt comfortable to raise an issue for consideration at the meetings and they felt encouraged to do so by the partners.

All staff received copies of the complaints and significant event meetings to ensure they were aware of any changes made. We saw evidence of action taken as a result of a significant event or a complaint. For example, a patient's medicine had not been noted on the system following a prescription from a consultant. This patient had then been referred for an operation and the anaesthetist was not aware of the consultant's prescription until the patient informed them. The operation was then cancelled. The practice reminded staff where they should be noting uncommon medicines on the system.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. We were told by one of the GP partners there was a lead professional for safeguarding children and vulnerable adults. We saw records showed GPs, nurses and other administration staff were either trained to level two or three for child protection in 2014. Staff had also been trained in safeguarding vulnerable adults in 2013.

Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. We heard of an example a nurse told us about a situation where they were concerned about a vulnerable patient who was displaying signs of psychological abuse. They had reported this to the GP who responded appropriately and had informed the local authority safeguarding team and health visitors. All staff we spoke with were aware who these lead practitioners were and who to speak within the practice if they had a safeguarding concern.

Our GP specialist advisor spoke with the lead GP for safeguarding they said they would speak with the health visitor and other colleagues about initial concerns about a child. We heard examples of when referrals had been made to the appropriate authorities.

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 who were the subject of a child protection plan. GPs ensured risks to children and vulnerable adults were flagged on the patient record system. This enabled practice staff to be aware these patients may need additional support and monitoring.

Requires improvement

Are services safe?

We saw the practice had posters in the waiting area advertising the availability of a chaperone as an option to patients when they had their treatment or consultations with practice staff. Receptionists who chaperoned for patients had received training from the nurse practitioner. However, we were told by the practice manager that receptionists who undertook this role had not undergone an appropriate criminal background check.

Medicines management

We checked medicines stored in the medicine refrigerators and the store room and found they were stored securely. We saw there was a record for daily monitoring of the refrigerator temperature. Processes were in place to ensure routine medicines were stock rotated, checked for expiry dates and were suitable for use. We spoke with one nurse who told us they had received training in child vaccinations in the last three years. The computer system identified when a child had not received a vaccination so it could be discussed when the child/parent next visited the practice. Nursing staff would also try to contact the parent/guardian if the child did not attend and if they were concerned would speak with the health visitor.

A member of the nursing staff was qualified as an independent prescriber and they received monthly supervision and support in their role by one of the GPs. This provided an opportunity to discuss clinical cases and scenarios relating to their prescribing role.

Acute and repeat prescriptions were computer generated and were authorised by the patient's GP. Reminders were flagged on the system if a medicine review was required for patients whose prescriptions were out of date. This helped to ensure patient's repeat prescriptions were still appropriate and necessary. We spoke with three nursing and residential homes in which the practice had registered patients and they told us the repeat prescription process was efficient and urgent prescriptions were actioned promptly in most cases. The practice had a turnaround of signing prescriptions within 48 hours of when the prescription request was received by the practice.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a secure controlled drugs cupboard and access to them was restricted; with the keys held securely. There were arrangements in place for the safe destruction of controlled drugs.

Cleanliness and infection control

Two patients commented they found the practice clean and had no concerns about cleanliness or infection control.

The practice had a lead professional for infection control who had undertaken further training to enable them to provide advice about the practice infection control policy and carry out staff training. We were told by the lead professional for infection control they had carried out two infection control audits in the last two years. The practice manager informed us plans were in place to improve the facilities, which were not yet completed in the treatment and consulting rooms including staff and patient toilets.

Notices about hand hygiene techniques were displayed in staff and patient toilets. We saw sharps were held in secure containers and stored securely when they were awaiting collection for disposal. The practice had an infection control policy, which was last reviewed in October 2014.

The practice had a risk assessment carried out in February 2014 for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records which confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. It was noted that on some occasions the hot taps were not reading more than 55 degrees, as directed by the practice risk assessment.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. For example, a blood spinning device, to enable the practice to keep blood samples overnight. This had been serviced in November 2014. We saw fire equipment had been tested and maintained in September 2014.

Staffing and recruitment

The practice had a recruitment policy which set out the standards it should follow when recruiting clinical and non-clinical staff. This policy was last reviewed in May 2012. We were told the practice used the same two locum GPs to

cover GP absence in the practice. We saw evidence from one locum GP used that evidence from the agency was gained in relation to the recruitment checks carried out, such as references, professional qualifications and criminal background checks.

The practice manager told us about the arrangements for planning and monitoring the number 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 there were enough staff 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.

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 in the practice. We saw fire safety checks, medicines management processes, staffing arrangements, dealing with emergencies and equipment. There was an identified health and safety representative and they told us they had received training. However, we noted from the training matrix that a number of staff were due or overdue to complete their updated training for health and safety.

We saw patients paper records were held within the staffing area of the practice were not always held securely. The room in which they were stored was used as an office by administration staff. We noted there was no lock on the door to keep the records secure. However, we were informed the main door upon entering the staffing area was kept locked throughout the day. We noted however this door was kept unlocked during staffing hours. The staffing area was also used by other health professionals such as the palliative care nurse, health visitors and staff employed by the citizen's advice bureau.

Staff told us they had received training in how to deal with the possibility of challenging behaviour from patients. They told us the practice had provided training in their induction about how to manage this type of situation effectively.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. GPs and nurses received annual training and administration staff completed basic life support training every three years.

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). When we asked members of staff, they all knew the location of this equipment. We heard of a medical emergency that had occurred approximately 18 months ago. The nurse practitioner told us this had been discussed at a significant event meeting. The practice had fed back their learning from this event to the other service involved.

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. The practice did not routinely hold stocks of medicines for the treatment of bradycardia, suspected bacterial meningitis, analgesia and medicines to reduce the effects of an opiate overdose. The reason for this was because one of the GP partners told us they had alternatives in place. For example, for the treatment of bradycardia they had a medicine for muscle spasm, which would not be appropriate or effective for this condition. The alternative they had for suspected bacterial meningitis was not in injectable form and so would not be appropriate to treat this condition.

The GP partner told us they did not have medicine for reducing the effects of an opiate overdose because they would rely on the emergency services. We were informed there was a rapid response paramedic vehicle would be called upon in emergencies and there were sometimes delays in transit ambulances to take patients to the nearest accident and emergency hospital. There was a potential risk that a patient could not be treated promptly in an emergency because they did not have the reversal medicine available.

Processes were also in place to check monthly whether emergency medicines were within their expiry date and suitable for use. All the medicines 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. Risks identified included power failure,

Requires improvement

Are services safe?

adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details of other professionals to which staff could refer. For example, contact details of a heating company to contact if the heating system failed.

The practice had carried out a fire risk assessment in 2011 this included actions required to maintain fire safety. We saw the majority of staff had completed fire training in 2012/2013. The practice had provided us with a training matrix prior to the inspection and we saw staff were overdue for this training. We saw with the exception of one staff member they had completed a practice fire evacuation this year. The practice also had a trained fire warden.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The nursing staff we spoke with clearly outlined 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 heard an example of when a medicine had been removed through national guidelines and so the practice processes had reflected this change. The practice manager took the responsibility to disseminate new guidelines to relevant staff. This was emailed to staff and any critical updates were discussed in nurse meetings.

The practice used computerised tools to identify patients with complex needs who had multi-disciplinary care plans documented in their case notes. All patients over the age of 75 years old were allocated a named GP.

We spoke with the medical secretary regarding the process for referrals. The computerised system highlighted urgent referrals initiated by the GP and these were always completed as a matter of priority and always by the end of the working day. We were told when an urgent referral was received this would be prioritised and confirmation of the referral was checked to ensure the hospital had received the referral.

We saw no evidence of discrimination when staff made care and treatment decisions.

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, and managing child protection alerts and medicines management.

We saw six clinical audits which had been undertaken in the last four years. We saw two out of the six audits had been re-audited a year later to show if any improvements had been made. One of the two re-audited audits had shown improvements since the last audit; this was for family planning. However, the audit had identified an action to review at the next audit. We saw from the next audit this had not been reviewed. The other audit for atrial fibrillation showed no improvements from the previous audit completed. However, a further audit had been completed by an external company in May and June 2014. This audit reviewed 91 of 159 patients who were deemed higher risk of atrial fibrillation and who may require anticoagulation therapy. This increased the percentage of patients requiring anticoagulation therapy from 82% to 96% in 91 patients. There were 159 patients deemed to be high risk who should be reviewed. There was no plan for an audit of these 68 patients but the GP partner told us they would each be reviewed at their next annual medicine review.

There should also be a formal process to ensure results and research from audits was shared with the team and new practice protocols formed, where necessary.

The practice had opted out of the quality and outcomes framework and had joined other practices in Somerset to use the Somerset practice quality scheme. The practice was part of a federation of seven other practices within the West Somerset area. This enabled them to share learning and joined up working within the community.

We saw the practice had a protocol for repeat prescribing which had last been reviewed in March 2013. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was used. The computer system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice carried out in-house anticoagulant checks for its patients. This was nurse led for patients visiting the practice or housebound patients and they informed us of the clear guidelines in place to ensure patients received the correct dose safely. The GPs had the responsibility to provide anticoagulant results for patients who resided in residential and nursing homes. GPs spoken with told us they either provided this information to the home verbally or they faxed the results to the home. However, we found there was not a clear protocol in place for GPs to follow. Guidance from the Health and Social Care Board, 'safe use of warfarin in primary care guidance' January 2014 states 'verbal dose changes may be required in the first instance but must always be confirmed in writing as soon as possible'.

The practice had identified patients on the palliative care register and had monthly multi-disciplinary meetings to

Good

Are services effective?

(for example, treatment is effective)

discuss the care and support needs of these patients and their families. The hospice palliative care team were based at the practice and they always attended these meetings. The majority of the GPs attended these meetings, which ensured a consistent approach to end of life care.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attendance at mandatory courses such as basic life support training. Administration staff completed life support training every three years, GPs and nurses completed annual training. We were told five GPs had completed advanced life support training. We noted a good skill mix among the GPs with three GPs having additional diplomas in obstetrics and gynaecology, one GP had a diploma in children's health and another GP had a diploma in family planning. All GPs were up to date with their yearly continuing professional development requirements and all have 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council.

The nurse practitioner informed us they completed the nurses' annual appraisal with the practice manager and they received their appraisal with the GP and practice manager. They told us they received regular monthly supervision by the GPs which was crucial for their development through discussions of complex cases and different practice scenarios that may occur.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage complex cases. They received blood test and X ray results and letters from the local hospital including discharge summaries and out of hours GP services both electronically and by post. The GPs had a buddy system for monitoring each other's results to cover sickness and annual leave and would action anything identified from results received. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients. For example patients with end of life care needs or children on the 'at risk' register. These meetings were attended by district nurses, health visitors and palliative care nurses.

The nurse practitioner had provided additional training for the local services. For example, they had provided training for staff to administer ear and eye drops for the life skills college. They had also provided additional tissue viability training for the nurses at one of the nursing homes.

Information sharing

The practice used electronic systems to communicate with other providers. For example, for making referrals, using the Choose and Book system. The Choose and Book system enables patients to choose which hospital they wish to be seen in and chose their own outpatient appointment times. Staff reported this system was easy to use.

The practice had 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 to coordinate, document and manage patients' care. All staff were fully trained to use the system, and the majority of staff 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.

Consent to care and treatment

We found staff had some awareness of the Mental Capacity Act (2005) and their duties in fulfilling it. We reviewed the practice processes for assessing patient's capacity when making advanced care decisions. We spoke with two GPs and the nurse practitioner about assessing capacity particularly in relation to advanced care planning and completing 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms. The two GPs confirmed they had delegated responsibility to the nurse practitioner to carry out advanced care planning with residents within a care home setting (advanced care planning is where decisions are made with the patient about future healthcare wishes if a patient lost capacity). The GPs spoken with told us they were not always aware of

Good

Are services effective?

(for example, treatment is effective)

decisions made when advanced care plans were completed. However, if the nurse practitioner had any concerns then this would be fed back to the patients named GP.

Health promotion and prevention

It was practice policy to offer a health check with the practice nurse or GP to all new patients registering with the practice. The GP was informed by the practice nurse of all health concerns detected if they had completed a new patient review. We observed a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18-25. The practice had actively offered nurse-led smoking cessation clinics to 81.5% of patients who had an identified smoking status.

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 register of all patients with a learning disability and all were offered an annual health check. Practice records showed 100% had received a check up in the year 2013 to 2014. The nurses told us they actively tried to promote health promotion through encouraging and supporting patients to live healthier lifestyles by seeing patients more regularly who needed motivational help, or advising patients about local support groups.

Annual health checks were carried out for patients with long term conditions and were recalled through the practice computer system. If patients missed their review the practice added notes onto their repeat prescription note to advise them to book an appointment. Patients who were housebound and/or resided in a residential or nursing home were seen in their own home for their annual health checks by the nurse practitioner.

The practice's performance for cervical smear uptake was 69% in the year 2013 to 2014, which was under the local CCG area average. There was a policy to write to patients who did not attend for cervical smear testing. The practice also had a nurse available when the practice was open with extended hours to carry out cervical smears for patients who found it difficult to attend during normal opening hours.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for child immunisations was just below or just above the local CCG average and the nurse told us any child who had not received their immunisations and they were concerned about the child then this would be discussed with the health visitor.

The practice had also held an open day to promote awareness of what the practice could offer regarding health promotion, such as smoking cessation and local support services. It was also an opportunity to encourage patients to sign up for online appointments. Patients could also get there blood pressure and cholesterol checked by the nursing team. We were told 120 patients and other members of the community attended this open day.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice regarding patient satisfaction. This included information from the national GP patient survey which consisted of a survey of 112 patients. The practice had completed a friends and family test of 298 patients and patient satisfaction questionnaires had been sent out by each of the practice partners during their revalidation process. The evidence from all these sources showed patients were satisfied with the way they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed 97% of patients rated the practice as their overall experience was good was 'among the best' of practices surveyed. The practice was also above average for its satisfaction with 94% of patients saying GPs listened to them during consultations.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 21 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. We also spoke with seven patients on the day of our inspection and shortly after our inspection.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. We observed consultation or treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw staff were careful to maintain patients' confidentiality when discussing treatments so their confidential information was kept private. The reception desk was within the waiting room area and receptionists answered patient telephone calls at the desk and were shielded by glass partitions which helped keep patient information private. In response to patient and staff suggestions, a confidential area to the side of the reception desk was adapted so patients felt more comfortable in talking about confidential matters. This reduced patients overhearing potentially private conversations between patients and reception staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance to abusive behaviour. Receptionists told us they had received training about how to diffuse potentially difficult situations.

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 there were a number of areas where patient satisfaction was less than the local CCG area, including 80% saying GPs were good at explaining tests and treatments and 86% saying their GP treated them with care and concern. The results from the practice's own satisfaction survey showed that 90% of patients said they were sufficiently involved in making decisions about their care and 89% of patients said they felt listened to by the GP. However, it was not evident which GPs were included in this survey, when the information was sourced and how many patients were surveyed.

Patients we spoke with on the day of our inspection told us 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.

Staff told us translation services were available for patients who did not have English as a first language. We did not see notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

We spoke with two patients who had suffered bereavement and were positive about the emotional support provided by the practice. They were particularly pleased with the time, support and care taken by the nurse practitioner.

Notices in the patient waiting room and the patient website informed patients of 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

Good

Are services caring?

written information available for carers to ensure they understood the various avenues of support available to them. The practice had a carer's champion for patients to gain support and advice from.

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 local area team and Somerset Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice had adjusted the area in the reception/waiting area to increase confidentiality for patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups of patients in the planning of its services. The practice recognised and encouraged carers to register as a carer with them to enable the practice to provide additional support, when required. The practice had a larger proportion of patients with a diagnosed learning disability in comparison to other practices within the area. They had adapted their services to meet their needs and all of these patients saw a named GP who carried out their annual health checks each year.

The practice provides care and treatment to approximately 100 patients who reside in a life skills college and working hotel for people with a learning disability. The practice had received an award from the Fox's academy community award 2014 for their support and patience in enabling learners work towards independence. We received positive comments from a member of staff at the college who also participates in the patient participation group. They told us their students saw the same GP, the service was easy to access and they were provided with prompt appointments when required. Students were invited and attended the patient participation group.

The practice had access to online and telephone translation services or patients would bring in their own translator, which could be a family member. They told us if the GP or nurse felt there was a confidentiality conflict then they would use the translation service.

The premises and services had been adapted to meet the needs of patients with disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. Patients who were hard of hearing could use the installed hearing loop at the reception desk.

Access to the service

Appointments were available from 8am to 6pm Monday to Friday and extended opening hours until 8:30pm on a Tuesday evening. The practice had a triage system for their sit and wait service which occurs Monday to Friday from 11:30am and from 4:30pm. For three out of the five days the nurse practitioner triaged patients who arrived for the sit and wait service. Patients completed an information assessment sheet which enabled the nurse to prioritise the order in which patients were seen. Another day in the week the nurse practitioner carried out home visits for patients. GPs have a duty cover system for when the nurse practitioner is not available to triage patients. This system ensured patients were seen urgently when needed. Patients had the option to book with the GP of their choice and were only triaged when they required an urgent appointment. The extended hours were particularly useful for patients who were employed and nursing staff would provide regular clinics on these days to cover treatments such as cervical smear testing or annual health checks.

Comprehensive information about appointments was available to patients 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 about the out of hour's service was provided to patients.

Are services responsive to people's needs?

(for example, to feedback?)

Longer appointments were available for patients who required them, often patients with complex health conditions. These also included appointments with a named GP or nurse. Home visits were made to three local residential and nursing homes by either the named GP or the nurse practitioner depending on the need. The homes confirmed if they needed an urgent appointment this was acted on quickly by the GP.

Patients were generally satisfied with the appointments system. They confirmed they could see a GP on the same day if they needed to and they could see another GP, if there was a wait to see the GP 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.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. The practice complaints leaflet was in line with recognised guidance and contractual obligations for GPs in England. The practice complaints policy needed to be updated to reflect current external organisations to which patients could refer their complaints if they were unsatisfied with the practice response. There was information available on how to complain on the practice website. We saw no information was displayed within the waiting area to help patients understand the complaint system. However, if they asked at reception there was a patient leaflet available to advise patients of the process to follow. Patients we spoke with were aware of the process to follow if they wished to make a complaint. One patient we spoke with was encouraged to raise their concerns with the practice.

We saw 16 complaints had been received in the last 12 months and found these were satisfactorily handled. They had been dealt with in a timely way, and demonstrated openness and transparency in dealing with the complaints.

The practice complaints were reviewed with all staff at a quarterly meeting to enable shared learning with staff from individual complaints.

Are services well-led?

(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 statement of purpose. The practice did not have a five year business plan or a formal plan for succession planning. We were informed their main priorities were appropriate cover for when a number of the GP partners were due to retire and this was discussed in business partner meetings. The practice aims and objectives included a statement that they would act with integrity and complete confidentiality to ensure a safe and effective service and environment.

Governance arrangements

We found the arrangements for governance do not always operate effectively and there had been no recent review of the information used to monitor performance. The practice had a number of policies and procedures in place to govern activity and these were available to staff via the desktop on any computer within the practice. We read 10 of these policies and procedures including safeguarding vulnerable adults and children, whistle blowing and recruitment policies. We found nine out of ten policies were either not been reviewed in the last year or did not have a date of when it had been produced. For example, the Mental Capacity Act 2005 consent policy had no date of when it had been produced; business continuity plan, repeat prescribing policy and the recruitment policy were all waiting to be reviewed.

We saw policies often did not reflect current guidance. For example, the child protection policy had been reviewed in August 2013 and was due for its next review in August 2016; however this did not reflect current guidance. For example, the policy did not describe the action staff should take either internally in the practice, or externally, if they were concerned about a child. Neither did the policy indicate how they could contact the external authorities, such as contact numbers in and outside of working hours. The policy described the signs of abuse and the role of the lead professional for child protection. Another example was the protection of vulnerable adult's policy which did not contain current information about the local safeguarding procedures, such as the lead GP and deputy lead names for staff to contact and the appropriate external contact if the concerns needed to be reported. Another example was for practice recruitment procedures not reflecting current legislation. For example, it did not include copies of proof of identification, evidence of qualifications or registration with the appropriate professional body or specific references required.

We observed the practice did not have a policy for clinical governance, which would include the processes in place for staff learning following incidents, audits and events.

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 senior partner was the lead professional for safeguarding. We spoke with eight 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 held monthly governance meetings with all the partners. We were told patient and practice risks were discussed at these meetings.

The practice previously used the Quality and Outcomes Framework (QOF) to measure its performance. In 2012/2013 they received 99% completion rate for their QOF work. The QOF data for this practice showed it was performing above national standards. In the last year 2013/2014 the practice had opted out of the QOF and was part of the Somerset practice quality scheme instead whilst still completing some of the QOF framework. The practice had a 65.5% completion rate for the QOF in 2013/2014. The Somerset practice quality scheme works with other practices in the area to decide on local patient improvement areas to enable them to focus on the needs of the area.

The results of clinical audits were not always used effectively to improve quality. GPs did not formally discuss results of clinical audits with other GPs or complete another cycle of audits to ensure processes were embedded. For example, a discharge summary audit had been completed in September 2013. This identified a number of changes to how the practice dealt with discharge summaries, such as delegating some responsibility to the prescriptions clerk. There had been no audit completed so the practice was unable to determine whether these processes had been embedded.

Four out of the six audits seen reviewed medicines management for gout and renal function, cryotherapy and discharge summaries did not have a complete cycle.

Are services well-led?

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

Completing a cycle would ensure recommendations had been followed and carried out by all GPs, confirm patients were receiving appropriate treatment and processes had been embedded with all GPs. We were told some audits we were told were discussed with the other GPs. However, there was no formal system for this and we found three of the audits did not confirm who had completed them. One audit in particular for patients with diabetes with an impaired renal function had been completed in February 2013 to review patients' medicine dosage or to see if their medicine should be stopped. We were informed that the computer system would provide a safety warning to check whether to prescribe the medicine. However this alert was only evident when the medicine was initially prescribed not when it was requested as a repeat medicine. The GP did not plan on carrying out another audit but would rely on a system of annual blood tests and medication review to ensure patient safety.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, every quarter. Staff told us that there was an open culture within the practice and they had the opportunity, and were confident, to raise issues at these meetings.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment and whistleblowing policies which were in place to support staff. As noted previously the recruitment policy did not reflect current guidelines GP practices should be following when recruiting new staff. The practice had a whistleblowing policy which described how staff would be supported if they wished to raise concerns about other members of staff or the practice. We saw this policy did not indicate when it was last reviewed.

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

The practice had gathered feedback from patients through patient surveys, the patient participation group (PPG), friends and family test and complaints received. The practice had completed the friends and family test throughout October 2014. This was a new national initiative for GP practices to ask their patients would they recommend the service to their friends and family. We saw 98% of the 298 patients surveyed had responded saying they would recommend the practice to friends and family. The main reasons for their decision was 64% confidence in the GP or nurse and 22% support by practice staff.

The PPG and the practice had agreed to capture patient views this year through the GPs revalidation, where the GPs survey's their own patients after consultations over a certain period. This process would be hard for the practice to determine the views of the practice as a whole, because it only captures the patient opinion of their GP and no other staff or practice amenities. The practice and PPG had previously completed practice surveys and had found confidentiality for patients had been a concern. Since the initial survey they had changed the reception area to increase confidentiality for patients.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups; including patients living in vulnerable circumstances, older people and working age patients. The minutes from the previous meeting were available on the practice website. The last meeting showed an agreement had been made to increase the size of the display screen in the waiting room to help patients see when they were due to be seen. We heard from a number of patients during our inspection that the screen had been an issue.

The practice had gathered feedback from staff through staff meetings and informal staff discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us regular appraisal took place which included a personal development plan. Staff told us the practice were supportive of training. The nursing team we spoke with told us they had regular bi-monthly meetings to discuss and share learning and training was provided if requested. For example, GP support was provided for note summarising for one member of staff because they wanted to improve their practice.

Where changes are made, the impact of quality of care is not fully understood in advance or it was not monitored.

Are services well-led?

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

We found staff did not always work in conjunction with each other to effectively implement practice procedures. Each GP had their own home visit bag and they were each responsible for checking the medicines were in date and contained the right medicines. We saw one of the GPs home visit bags and observed all medicines were in date. However, the GP told us the medicines were checked by the nursing staff and the nursing staff told us the GPs had the responsibility for these bags. It was therefore unclear who took responsibility for checking the medicine bags. We spoke with one of the GP partners who told us they thought they had medicine in their bag to treat suspected bacterial meningitis. We found they did not have this medicine in their bag. During our feedback with the practice they told us they normally kept this in the fridge. However, later they confirmed the practice had a similar medicine but this was not in an injectable form and did not follow national guidance. The practice should have a protocol in place to ensure medicines kept in the home visit bags were risk assessed based on the needs of patients and the challenges of the area and all staff using the home visit bags should be aware of what medicines were in them.

The policies and procedures should be implemented and understood by staff. For example, the Mental Capacity Act policy provided good information about how capacity should be assessed if they felt the patient lacked capacity when making important decisions about their health and welfare. However, the policy did not reflect what procedures individual delegated staff should follow when dealing with advanced care plan decisions. For example, the GPs had delegated authority to the nurse practitioner to complete assessments for patients who reside in a residential or nursing home who required an advanced care plan, but there was no clear protocol of the GPs expectations in line with the required 'best interest' decision making process outlined in the Act.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers (1)The registered person must protect service users and others who may be at risk, against the risks of inappropriate or unsafe care and treatment, by means of the effective operation of systems designed to enable the registered person to (a) regularly assess and monitor the quality of the services provided in the carrying on of the regulated activity against the requirements set out in this part of these regulations; (2)for the purposes of paragraph (1), the registered person must (b) have regard to (iii) the information contained in the records referred to in regulation 20, (iv) appropriate professional and expert advice (including any advice obtained pursuant to sub-paragraph (a)) (c) and where necessary, makes changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to (ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services

This section is primarily information for the provider

Compliance actions

Surgical procedures Treatment of disease, disorder or injury	The registered person must have procedures in place for dealing with emergencies which are reasonably expected to arise from time to time and which would, if they arose, affect, or be likely to affect, the provision of services, in order to mitigate the risks arising from such emergencies to service users.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 20 HSCA 2008 (Regulated Activities) Regulations 2010 Records (2) The registered person must ensure that the records referred to in paragraph (1) (which may be in paper or electronic form) are (a) kept securely and can be located promptly when required