Brent Area Medical Centre

Quality Report

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

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Brent Area Medical Centre on 3 September 2015. Overall the practice is rated as good. Specifically, we found the practice to be outstanding for providing responsive services. The practice was good for providing safe; effective; caring and well-led services.

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.
- Risks to patients were assessed and well managed.
- 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 said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice supported the local population and actively engaged and challenged commissioners. For example, when the district nursing treatment room service was to be relocated.
- 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:

Summary of findings

- The practice was proactive in identifying, recording and managing risks and concerns raised by the health care provided by other organisations. This included raising concerns with the Clinical Commissioning Group (CCG) in addition to required notifications; engaging and working with partner agencies to share action plans and lessons learnt.
- There were high levels of staff satisfaction and the practice worked to ensure staff were proud of the organisation. For example, setting up of a local practice nurse forum; results from a county survey of GP practices placed the practice in the top two practices where staff were enthusiastic and motivated about their roles.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example, a weekly walking health group for patients; the setting up of a local support group , Village Agents, for socially isolated, excluded, vulnerable and lonely patients and securing funding for a 'singing for the brain' group.
- Practice staff actively engaged in providing patients with a high quality of care above the service expectations. For example, staff delivered patients prescriptions on their way home; GPs visited unwell or recently discharged patients at weekends.

However there was an area of practice where the provider should make improvements:

- The practice should consider the use of alerts on their record keeping system so that any new member or temporary members of staff were aware of any impacts on health management.

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. The practice used every opportunity to learn from internal and external incidents, to support improvements. Lessons were learned and communicated widely to support improvements. 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?

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 from the National Institute for Health and Care Excellence and used it routinely. Patients' 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 for patients about the services available was easy to understand and accessible. 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 their patients that were over and above their contractual obligations. The practice had 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 the local population and

Summary of findings

engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified. For example, when the district nursing clinic service was to be relocated out of the area.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they 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

Good

The practice is rated as good 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 patient in its population and had a range of enhanced services, for example, in dementia and end of life care. 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 set up a local scheme to provide extra support for the isolated frail elderly patients, and patients with long term conditions in the locality.

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 medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

The GP partners and nurse had undergone additional training to be able to offer patients care plans.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies.

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

Summary of findings

working age population, those recently retired and students had been identified and the practice had adjusted the services offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances. They had carried out annual health checks for patients with a learning disability and 100% of these patients had received a follow-up. The practice offered longer appointments for patients with a learning disability.

Patients living with a learning disability in a local residential home were offered home visits or if they attended the practice staff would collect them from the car park in order to reduce anxiety for patients who found it hard to access the service.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Vulnerable patients were informed 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 provided food bank vouchers.

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). All 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 patients experiencing poor mental health, including those with dementia. The practice carried out advance care planning for patients with dementia.

The practice had informed patients experiencing poor mental health about how to access various support groups and voluntary organisations. They 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 patients with mental health needs and dementia.

One GP was the dementia lead for the local GP federation.

Summary of findings

What people who use the service say

The national GP patient survey results published on 4 July 2015 showed the practice was performing well above local and national averages. There were 129 responses and a response rate of 52.4%.

- 97.6% find it easy to get through to this surgery by phone compared with a Clinical Commissioning Group (CCG) average of 78.6% and a national average of 74.4%.
- 95.4% find the receptionists at this surgery helpful compared with a CCG average of 89% and a national average of 86.9%.
- 92.4% with a preferred GP usually get to see or speak to that GP compared with a CCG average of 65.3% and a national average of 60.5%.
- 97.8% were able to get an appointment to see or speak to someone the last time they tried compared with a CCG average of 88.8% and a national average of 85.4%.
- 95.3% say the last appointment they got was convenient compared with a CCG average of 93.7% and a national average of 91.8%.
- 90.3% describe their experience of making an appointment as good compared with a CCG average of 79.2% and a national average of 73.8%.
- 78.8% usually wait 15 minutes or less after their appointment time to be seen compared with a CCG average of 70.1% and a national average of 65.2%.
- 78.4% feel they don't normally have to wait too long to be seen compared with a CCG average of 63.1% and a national average of 57.8%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 82 comment cards which were all positive about the standard of care received. Patients said that the practice dispensary was invaluable to a local community with poor public transport; the service was prompt and efficient; staff were helpful and dedicated to provide a personal service and the care was excellent by staff who listened and treated patients with dignity, care and respect.

Areas for improvement

Action the service SHOULD take to improve

- The practice should consider the use of alerts on their record keeping system so that any new member or temporary members of staff were aware of any impacts on health management.

Outstanding practice

- The practice was proactive in identifying, recording and managing risks and concerns raised by the health care provided by other organisations. This included raising concerns with the Clinical Commissioning Group (CCG) in addition to required notifications; engaging and working with partner agencies to share action plans and lessons learnt.
- There were high levels of staff satisfaction and the practice worked to ensure staff were proud of the organisation. For example, setting up of a local practice nurse forum; results from a county survey of GP practices placed the practice in the top two practices where staff were enthusiastic and motivated about their roles.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice. For example, a

weekly walking health group for patients; the setting up of a local support group , Village Agents, for socially isolated, excluded, vulnerable and lonely patients and securing funding for a 'singing for the brain' group.

- Practice staff actively engaged in providing patients with a high quality of care above the service expectations. For example, staff delivered patients prescriptions on their way home; GPs visited unwell or recently discharged patients at weekends.

Brent Area Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector. The team included a GP specialist adviser and a second CQC inspector.

Background to Brent Area Medical Centre

The practice is located in East Brent, a village located close to the M5 motorway, 5 miles (8.0 km) west of Axbridge and on the edge of the Somerset Levels in the Sedgemoor district of the county of Somerset. The practice provides primary medical services for four local villages with some additional patients from two nearby towns.

The practice is located in a converted Victorian house which contained three consulting rooms; a treatment room and a dispensary. The practice supports the local community responder scheme by providing, without charge, the cost of housing a Community Heartbeat Trust defibrillator at the entrance.

The practice has a population of approximately 2669 patients. The practice dispenses medicines to 90% of the practice population from a single room in the surgery. The practice has a higher than England average of patients aged between 45 and 84 years and a higher than Clinical Commissioning Group (CCG) average of patients aged between 50 and 60 years of age. The practice is situated in an area with lower deprivation with a deprivation score of 12.1 compared to the CCG average of 16.8 and the national average of 23.6 with only 3% living in the most deprived 10% of neighbourhoods in Somerset and 10% living in the 20% most deprived areas.

The practice team includes two GP partners, one male and one female, (who have been in a partnership since 1994) providing a whole time equivalent of 1.5; a part time practice nurse and health care assistant; practice manager and administrative staff which include dispensary staff; receptionists; a secretary and an IT coordinator. In addition a GP from a local practice provides locum work one day every week.

The practice is a training practice for medical students with one GP providing training support. At the time of our inspection a final year medical student was being supported by the practice.

The practice had a General Medical Services contract (GMS) with NHS England to deliver general medical services. The practice provided enhanced services which included facilitating timely diagnosis and support for patients with dementia; learning disabilities and minor surgery.

The practice is open between 8:30am to 6:15pm Monday to Thursday. On Friday the practice is open from 8:30am to 12:30pm and 2pm to 6.15pm. Telephone access is available from 8am to 6:30pm daily. Extended hours surgeries are no longer offered due to poor take up from patients. The practice provided 16 GP sessions per week between 08:30am to 12:20pm and 14:30pm to 17:45pm. The national GP patient survey (July 2015) reported that patients were satisfied with the opening times and making appointments. The results were above local and national averages.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 and Somerset Urgent Care Doctors provide an Out Of Hours GP service.

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

We carried out an announced visit to the practice on 3 September 2015. During the inspection we spoke with eleven staff and five patients, looked at documentation and observed how patients were being cared for.

We reviewed comments cards, sent to the practice in advance of our visit for patients to complete. These were where patients and members of the public shared their views and experiences of the service.

In advance of the inspection we reviewed the information we held about the provider and asked other organisations to share what they knew.

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
- 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).

Good

Are services safe?

Our findings

Safe track record and learning

There was an open and transparent approach and a system in place for reporting and recording significant events. Patients affected by significant events received a timely and sincere apology and were told about actions taken to improve care. Staff told us they would inform the practice manager of any incidents and there was also a recording form available on the practice's computer system.

We reviewed safety records, incident reports of eight significant events (from April 2014 to present day) and minutes of meetings where these were discussed. We saw the practice had a comprehensive filing system with significant events recorded for the past eight years. There were robust arrangements for identifying, recording and managing risks and issues with patient care. The practice carried out an analysis of the significant events which included actions taken and lessons learnt. We saw that changes in practice had taken place as a result of the events.

Lessons were shared to make sure action was taken to improve safety in the practice. We saw that the practice involved partnership agencies in significant event analysis. For example, a local care home had failed to collect a patient's prescription that led to an emergency situation. The practice undertook an investigation involving the home in the process which led to the care home changing their protocols around prescriptions and updating staff on the findings.

We also saw that the practice was good at reporting incidents to the Clinical Commissioning Group (CCG) and NHS England using patient safety and risk management software. We saw that the practice was very proactive when dealing with concerns resulting from hospital discharges. For example, we saw that any incidents were investigated by the practice. In addition patient safety alerts were raised with the CCG and letters of concern sent to the hospitals to request internal investigations. We looked at these events. For example, a patient was discharged without having staples removed; discharge letters listed medicines that the patient was not discharged home with and an end of life care patient discharged home with no medicines for pain control. We saw that the practice was persistent with following up concerns and ensuring patients received an appropriate investigation. There was evidence that the practice identified and acted on themes and trends around concerns for patient care. We also saw that the practice compiled reports and used alert systems to the Clinical Commissioning Group around concerns to patient safety.

Safety was monitored using information from a range of sources, including National Institute for Health and Care Excellence (NICE) guidance. This enabled staff to understand risks and gave a clear, accurate and current picture of safety. The practice used the National Reporting and Learning System (NRLS) eForm to report patient safety incidents. We saw that a recent national alert for a blood monitoring device had been actioned in a timely way with patients receiving an easy read letter and instructions. The alert contained clear descriptions of actions taken, when and by whom.

The practice used a medicines management tool which highlighted potential medicine related safety concerns.

Overview of safety systems and processes

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

- Arrangements were in place to safeguard adults and children from abuse that reflected relevant legislation and local requirements and policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and provided detailed examples of concerns that they had raised with other agencies. We saw that all staff had received advanced training (level three) in safeguarding vulnerable patients.
- A notice was displayed in the waiting room, advising patients that staff would act as chaperones, if required. All staff who acted as chaperones were trained for the role and had received a disclosure and barring check (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Good

Are services safe?

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a dedicated health and safety noticeboard. The practice had up to date fire risk assessments and regular fire drills were carried out. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice also had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health; infection control and legionella.
- Appropriate standards of cleanliness and hygiene were followed. We observed the premises to be clean and tidy. The cleaning company undertook monthly audits which were fed back in the monthly meeting with the company. The practice nurse was the infection control clinical lead who was supported by the practice manager as non-clinical lead. They liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example, carpets had been replaced with appropriate flooring.
- Recruitment checks were carried out and the two files we reviewed showed that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was an extensive rota system in place for all the different staffing groups to ensure that enough staff were on duty which included locum cover. For example, when one GP is on holiday.

Medicines management

There were systems in place for the safety of dispensary staff and medicines. The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme (DSQS) to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency reviewed annually. We saw the practice undertook regular audits within the dispensary. For example the practice was currently reviewing instructions given to patients to optimise the effectiveness of the medicine.

We saw the dispensary had well-ordered storage of medicines for dispensing and completed prescriptions for collection. Stocks of medicines were entered into the computer system to monitor quantity and assist with quality control and auditing. Staff were alerted to any changes in brand of medicines. Controlled medicines that required additional secure storage were kept secure and standard operating procedures were in place that set out how they were managed. For example, the dispensary manager audited controlled medicines monthly. All staff had received training on how to manage the arrival of new stock in the dispensary.

Regular medicines audits were carried out with the support of the local Clinical Commissioning Group (CCG) pharmacy team to ensure the practice was prescribing in line with best practice guidelines for safe prescribing. The practice held regular dispensing meetings for all staff with involvement in the dispensary. One GP took a lead role within the local GP federation (a group of five practices who work with the CCG to commission services) as the prescribing lead.

The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing and security). Prescription pads were securely stored and there were systems in place to monitor their use.

The nurse used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2014. We saw evidence that the nurse had received appropriate training and been assessed as competent to administer the medicines referred to under a PGD.

Good

Are services safe?

We saw that the practice did use some alerts for medicines on patient records. We fed back to the practice the benefits of increased use of alerts so locum staff would have a better understanding of patients medicines and possible interactions.

Arrangements to deal with emergencies and major incidents

There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency. All staff received basic life support training and there were emergency medicines available in the treatment room. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. There was also a first aid kit and accident book available. Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and fit for use.

The practice had a comprehensive and easily accessible business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice carried out assessments and treatment in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines. The practice had systems in place to ensure all clinical staff were kept up to date. The practice had access to guidelines from NICE and used this information to develop how care and treatment was delivered to meet the needs of the patients. The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in a local quality and outcomes framework, Somerset Practice Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (This is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the SPQS and performance against national screening programmes to monitor outcomes for patients. Current results were 91.5% of the total number of points available, with 7.65% exception reporting. (Exception reporting ensures that GP practices are not penalised where, for example, patients do not attend for review, or where a medicine cannot be prescribed due to a contraindication or side-effect).This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2013/14 showed;

- Performance for diabetes related indicators was 89.5% which is better than the Clinical Commissioning Group (CCG) average of 81% and the national average of 85.1%.
- Performance for mental health related and hypertension indicators was 100% which was better than the CCG average of 93.1% and the national average of 96.3%.
- The percentage of patients with a dementia diagnosis who have had their care reviewed in the past twelve months 92.3% which was better than the CCG average of 63.4% and the national average of 83.8%.

Clinical audits were carried out to demonstrate quality improvement and all relevant staff were involved to improve care and treatment and patients outcomes. We reviewed seven clinical audits completed in the last two years, one of these was an updated audit following changes in national guidelines and one was a re-audit to identify where the improvements made were implemented and monitored. The practice participated in applicable local audits, national benchmarking, accreditation, peer review and research. Findings were used by the practice to improve care and treatment.

Information about patients' outcomes was used to make improvements. For example, one GP undertook an audit around referrals to the Orthopaedic consultant. This led to identification that a number of patients could be referred to the podiatrist instead. The practice changed their referral pattern and then undertook an audit one year later to confirm that appropriate referrals were continuing.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for newly appointed non-clinical members of staff that covered such topics as safeguarding, fire safety, health and safety and confidentiality.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet these learning needs and to cover the scope of their work. This included ongoing support during sessions, one-to-one meetings, appraisals, coaching and mentoring, clinical supervision and facilitation and support for the revalidation of doctors. All staff had had an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire procedures, basic life support and information governance awareness. Staff had access to and made use of e-learning training modules and in-house training.
- The practice encouraged staff to request training that would support them in their role. For example, an administrator undertook a managing health services diploma.
- Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and we saw evidence that they were trained appropriately to fulfil these duties.

Good

Are services effective?

(for example, treatment is effective)

- The practice manager and one GP led the formation of a local practice nurse forum to provide education; peer support and support towards nurse revalidation.
- The practice provided staff with up to date journals and books about health care management. We saw that a comprehensive collection was available to all staff.
- One GP had expertise in respiratory medicine having worked in the hospital chest clinic as a specialist doctor.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and intranet system. This included care and risk assessments, care plans, medical records and test results. Information such as NHS patient information leaflets were also available. All relevant information was shared with other services in a timely way. For example, when patients were referred to other services. We saw that the practice was very good at feeding back to other organisations about the care their patients received. For example, when a hospital discharge was unsatisfactory or a partner organisation provided patients with inadequate prescriptions.

Staff worked together and with other health and social care services to understand and meet the range and complexity of patients' needs and to assess and plan on-going care and treatment. This included when patients moved between services, including when they were referred, or after they are discharged from hospital. We saw evidence that multi-disciplinary team meetings took place on a monthly basis and that care plans were routinely reviewed and updated. The GPs had an open door policy for health professionals that were holding clinics in the practice.

Consent to care and treatment

Patients' consent to care and treatment was always sought in line with legislation and guidance. Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, assessments of capacity to consent were also carried out in line with relevant guidance. Where a patient's mental capacity to consent to care or treatment was unclear staff sought advice from the GP and where appropriate, recorded the outcome. The practice used an alert system to notify staff if patients lacked the capacity to make an informed choice or had a appointed one or more people (known as 'attorneys') to help them make decisions or to make decisions on the patients' behalf.

Health promotion and prevention

Patients who may be in need of extra support were identified by the practice. These included patients in the last 12 months of their lives, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. Patients who may be in need of extra support and would benefit from proactive care planning were identified quarterly, using a risk profiling tool. Patients, if necessary, were then signposted to the relevant service.

The practice provided additional services to the patient population which included talking therapies and a walking group. A dietician was available on the premises; smoking cessation advice was available from a local support group and the practice referred patients to a local exercise scheme. The practice provided food bank vouchers to those in need.

The practice had a comprehensive screening programme. The practice's uptake for the cervical screening programme was 87.4% which was comparable to the Clinical Commissioning Group (CCG) average of 81.3% and the national average of 76.9% The practice also encouraged patients to attend national screening programmes for bowel and breast cancer screening.

Childhood immunisation rates for the vaccinations given were slightly above Clinical Commissioning Group (CCG) averages. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 90% to 100% compared to the CCG average of 82% to 97% and five year olds was 100% compared to the CCG average of 92% to 97%. Flu vaccination rates for the over 65s were 80.24% and for patients defined as in an at risk group was 63.16% which were both above the national average of 73.24% and 52.29%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients. Patients aged 40–74 without a pre-existing condition, were offered a health check for circulatory and vascular health and included identifying patients at risk of a vascular disease. Appropriate follow-ups on the outcomes of health assessments and checks were made, where abnormalities

Good

Are services effective?

(for example, treatment is effective)

or risk factors were identified. The practice regularly provided checks for high blood pressure with 91% of adult patients having a blood pressure check in the last five years.

We saw that:

- 90.2% of patients had a record of smoking status and 91.2% had been offered support to stop. This was above the CCG and national averages.
- The practice maintained a register of patients with obesity. Patients were encouraged to attend the in-house dietician and the local exercise on prescription scheme.
- The waiting room and patient information screens were used to provide patients with healthy living advice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We observed throughout the inspection that members of staff were courteous and very helpful to patients both attending at the reception desk and on the telephone, treating patients with dignity and respect. We saw that staff had positive attitudes towards the patients and demonstrated that they were considerate, kind and caring.

All of the 82 patient CQC comment cards we received were very positive about the service experienced. Patients said they felt the practice offered an efficient service and staff were considerate; helpful; caring; dedicated and treated them with dignity and respect. Comment cards highlighted that staff made patients feel relaxed and provided opportunities and time for patients to talk about their problems, responding compassionately when they needed help and providing support when required. We also spoke with the chair of the patient participation group (PPG) on the day of our inspection. They told us that patients were more than satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey showed patients were happy with how they were treated and that this was with compassion, dignity and respect. The practice was performing well in line with the Clinical Commissioning Group (CCG) and national average for satisfaction scores on consultations with doctors and nurses. For example:

- 97.6% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95.3%
- 79.2% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.9% and national average of 85.1%.
- 95% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 90.4%.
- 95.4% patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 86.9%.

In addition the practice was aware of and taking action on low results from the national GP patient survey:

- 82.1% said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91.6% and national average of 88.6%.
- 88.3% said the GP gave them enough time compared to the CCG average of 89.8% and national average of 86.8%.

Results from the NHS friends and family test from January 2015 until July 2015 showed that 100% of patients who responded would recommend the practice to others.

We saw that the practice went beyond the provision of the usual services because they respected and valued the patients. For example, one housebound patient required medicines to be administered daily. Other health services had opted out of providing this care so one GP went to visit the patient daily, including weekends. One patient told us that a GP had visited over the weekend when the patient had been discharged from hospital with medical equipment to manage their condition. Practice staff including GPs would deliver patients medicines if they were passing by their home. We were told about a patient that had run out of an inhaler on a Friday afternoon and how staff had ensured that an inhaler was delivered prior to the weekend.

Curtains were provided in consulting 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. Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed and they would offer them a private room to discuss their needs.

Care planning and involvement in decisions about care and treatment

Patients we spoke with 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 available to them. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Results from the national GP patient survey we reviewed showed patients responses to questions about their involvement in planning and making decisions about their care and treatment which were lower than local and national averages. For example:

- 75.9% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 90.1% and national average of 86.3%.
- 80.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86.1% and national average of 81.5%.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient and carer support to cope emotionally with care and treatment

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

The practice's computer system alerted GPs if a patient was also a carer. There was a practice register of all patients who were carers and 2.4% of the practice list had been identified as carers and were being supported, for example, by offering health checks and referral for social services support. Written information packs were available for carers to ensure they understood the various avenues of support available to them.

The practice had provided training for one receptionist to become a carers champion. As the practice was situated within a local community where the majority of patients had lived for a length of time, the practice were able to identify carers and provide support easily.

Staff told us that if families had suffered bereavement, their usual GP contacted them and the practice always sent a personalised sympathy card. We were told about the feedback from patients who received cards. One patient had received three cards after a bereavement and had told the practice that their card made the patient feel supported. Patients were either followed up with a 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 practice had set up a walking group that met at the surgery once a week to provide one hour walks. The practice told us about the positive physical and emotional benefits that the walking group had had on patients recently bereaved and patients experiencing poor mental health.

Talking therapies was provided weekly in the practice.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice worked with the local Clinical Commissioning Group (CCG) to plan services and to improve outcomes for patients in the area. For example, one GP was the local chair and dementia lead for the local federation and the practice manager was the local federation lead for practice managers. One GP was the prescribing lead for the federation and attended the CCG monthly medicines meetings.

Services were planned and delivered to take into account the needs of different patient groups and to help provide ensure flexibility, choice and continuity of care. For example;

- Routine appointments were for 15 minutes and there were longer appointments available for patients with a learning disability; mental illness or multiple long term conditions.
- At the request of patients an open surgery was provided every morning.
- The practice offered flexibility with appointments to enable patients using public transport to attend at a suitable time.
- Home visits were available for older patients and patients who would benefit from these. This included patients that required treatments that other health services opted out of providing. For example, housebound patients who required vaccinations.
- Urgent access appointments were available for children and those with serious medical conditions.
- There were facilities for people with a disability. Hearing loop and translation services were available.
- The practice dispensed medicines to 90% of the practice population.
- Monthly multi-disciplinary meetings were held with other professionals. For example, the hospice staff and community nurses.
- Patients living with a learning disability in a local residential home were offered home visits or if they attended the practice staff would collect them from the car park in order to reduce anxiety for patients who found it hard to access the service.
- The practice proactively lobbied and ensured that a local district nursing clinic was not transferred out of the local area.
- The practice manager set up the Somerset Village Agent project for the local GP federation. The project uses trained individuals living in the local parish to support socially isolated, excluded, vulnerable and lonely patients.
- The practice staff delivered prescriptions to patients who they knew would have difficulty attending the practice due to health or access problems. This included outside of practice hours.
- The practice and patients provided examples of how staff provided care outside of the expected provision of the service. For example, visiting patients at the weekend if staff had concerns for them.
- The practice raised money for other organisations where the practice patients would benefit. For example, we saw a letter of thanks from a local hospital for taking part in the hospital fete and a charity for money raised by selling books in the practice.
- The practice provided patients with additional services including a walking group and talking therapies.

Access to the service

The practice was open between 8:30am and 6:15pm Monday to Thursday. On Fridays the practice opened between 8:30am and 12:30pm and 2pm to 6:15pm. Telephone access was from 8:00am and 6:30pm Monday to Fridays. Morning appointments were available between 9:00am and 12:20pm except Wednesday where appointments were available from 8:30am to 12:20pm. Afternoon appointments were available from 2:30pm until 4:45pm on Mondays and from 2:30pm to 5:45pm on other weekdays. All routine appointments were for fifteen minutes and care plan reviews for thirty minutes.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them. The practice operated an open surgery weekday mornings.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was above the local Clinical Commissioning Group (CCG) and national averages. For example:

- 84.8% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 77.2% and national average of 75.7%.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

- 97.6% patients said they could get through easily to the surgery by phone compared to the CCG average of 78.6% and national average of 74.4%.
- 90.3% patients described their experience of making an appointment as good compared to the CCG average of 79.2% and national average of 73.8%.
- 78.8% patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70.1% and national average of 65.2%.

Patients we spoke with on the day were able to get appointments when they needed them.

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 information was available in the waiting room and on the practice website to help patients understand the complaints system. The practice also provided a comments box in the waiting room. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We looked at the three complaints received since April 2014 and found these were satisfactorily handled and dealt with in a timely way. We saw that the practice was open and transparent when dealing with the complaints; patients were kept up to date and actions were taken to improve the quality of care. For example, we saw that the practice sought advice from Local Medical committee (LMC) following a complaint about a GP. The GP wrote and apologised to the patient who wrote back expressing a wish to move forward with the relationship.

We saw lessons learnt from individual complaints had been acted upon and the complaints discussed at practice meetings and joint surgery meetings to improve the quality of care delivered.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement and staff knew and understood the values. The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities.
- The practice utilised a document management system to streamline working processes and improved data quality which allowed GPs to concentrate on providing more joined up patient care.
- Practice specific policies were implemented and were available to all staff.
- The leadership had a comprehensive understanding of the performance of the practice.
- A programme of clinical and internal audit was used to monitor quality and to make improvements to care. Audits were shared and discussed with relevant staff.
- There were robust arrangements for identifying, recording and managing risks and issues with patient care. We saw that the practice was firm and persistent in following up episodes of unsatisfactory care from other health providers and implementing mitigating actions. We saw that their management of concerns provided a focus on learning and improvement.

Leadership, openness and transparency

The partners in the practice had over twenty years' experience of running the practice together. The practice ethos was to deliver high quality holistic care in line with best practice guidelines. We saw that the practice prioritised safe, high quality and compassionate care. The partners and practice manager were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The partners encouraged a culture of openness and honesty.

Staff told us that regular team meetings were held. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice proactively encouraged, valued and gained feedback from patient. Patients were engaged in the delivery of the service through the patient participation group (PPG) and through surveys and complaints received. There was an active PPG with sixteen members which included representation from patients with a disability; young people; working aged patients and patients who were carers. The PPG met on a regular basis; provided a medicines delivery service; carried out patient surveys and submitted proposals for improvements to the practice management team. For example. The local singing for the brain group for patients living with a dementia was being moved to a nearby town. The PPG have set up and funded a local music for the memory group for the local population; worked with the practice to improve access for patients with a disability and collated information on local support groups which was accessible in the reception area.

The practice had also gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run. For example, staff were involved in discussions about the introduction of care plans for patients with long term conditions; reception staff raised concerns over confidentiality when the music licence was not renewed due to cost. The partners agreed to reinstate the music.

Staff told us that they felt rewarded by the practice management. One GP always thanked staff every day prior to leaving.

Are services well-led?

Good

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

A recent survey by the Local Medical Committee (LMC) looking at practice staff's enthusiasm and motivation resulted in the practice being placed in the top two practices where staff were enthusiastic and motivated about their roles.

Innovation

There was a strong focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, a pilot scheme to introduce supportive care plans for patients in Somerset.

The practice worked with other local GPs on a plan to provide collaborative services for the local population.