College Way Surgery

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?	Good
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out our inspection on 25th November 2014. We inspected College Way Surgery as part of our new comprehensive inspection programme.

Overall we found the practice is rated as good with some aspects of their practice being outstanding. We saw many examples of a safe, effective, caring, responsive and well led practice. Patients reported high levels of satisfaction with the practice during our inspection and this was reflected in the comment cards we also received.

Our key findings were as follows:

- Staff understood and fulfilled their responsibilities to raise concerns and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.
- Our findings at inspection showed systems were in place to ensure all clinicians were up to date with both NICE guidelines and other locally agreed guidelines. We saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed that the practice was performing highly when compared to neighbouring practices in the Somerset Clinical Commissioning Group (CCG) and nationally. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.
- Data showed patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw staff treated patients with kindness and respect and maintained confidentiality.
- The practice reviewed the needs of its local population and engaged with the NHS area team and 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 that there was continuity of care, with urgent appointments available

Summary of findings

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 that the practice responded quickly to issues raised. Learning from complaints with staff and other stakeholders.

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using available technology, and it had a very active patient participation group (PPG).

We saw several areas of outstanding practice including:

- Following patient feedback from the last patient participation group survey the practice had commenced a series of educational events for patients, most recently about diabetes.
- The practice had adopted a call centre approach to their telephone booking system with up to 12 lines being available for incoming and outgoing calls.
- Constant monitoring of the appointment system provided additional appointments if needed and in-house locums were booked where demand exceeded planned appointments.
- The practice had worked towards being a dementia friendly practice. The entire practice staff team had received training from the attached pharmacist who is a Dementia Champion.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep people safe.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. We also saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data provided in the Care Quality Commissions data pack showed that the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group (CCG) and nationally. The practice was using innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS Area Team and Clinical Commissioning 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 that there was continuity of care, with urgent appointments available the same day.

Summary of findings

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 that the practice responded quickly to issues raised. The practice shared learning from complaints 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 with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff; teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

Summary of findings

What people who use the service say

We spoke with eight patients visiting the practice and six members of the patient participation group during our inspection. We received 22 comment cards from patients who visited the practice and saw the results of the last and previous two patient participation group surveys. The practice also shared their initial findings from their current 'friends and family' survey. We also looked at the practices NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice.

The majority of comments made or written by patients were very positive and praised the care and treatment they received. For example; about receiving the right treatment at the right time, about seeing a named GP at most visits and about being involved in the care and treatment provided.

We heard and saw patients generally found access to the practice and appointments easy and how telephones were answered after a brief wait. However, some comments made indicated it was not always easy to get through to the practice during the first hour of the practice opening. The most recent GP survey showed 88% of patients found it easy to get through to the practice by telephone. Patients also told us they used the practices online booking systems to get appointments.

We saw a range of thank you cards sent to GPs in the practice. These all thanked staff for their caring approach and their support at times of emotional need and ill health.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was sufficiently private for most discussions they needed to make. Patients told us about GPs supporting them at times of bereavement and providing extra support to young carers. A large number of patients had been attending the practice for over 15 years and told us about how the practice had grown but that they were always treated well. The GP survey showed 94% of patients said the last GP they saw or spoke with was good at giving them enough time and treating them with care and concern.

Patients told us the practice was always kept clean and tidy and periodically it was refurbished and improved facilities added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with paper protective sheets. 97% of patients describe their overall experience of this practice as good.

Areas for improvement

Outstanding practice

- Following patient feedback from the last patient participation group survey the practice had commenced a series of educational events for patients, most recently about diabetes.
- The practice had adopted a call centre approach to their telephone booking system with up to 12 lines being available for incoming and outgoing calls.
- Constant monitoring of the appointment system provided additional appointments if needed and in-house locums were booked where demand exceeded planned appointments.
- The practice had worked towards being a dementia friendly practice. The entire practice staff team had received training from the attached pharmacist who is a Dementia Champion.

College Way Surgery

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, a practice manager, a practice nurse and an expert by experience. Experts by Experience are people who have experience of using care services. They take part in our inspections of health and social care services

Background to College Way Surgery

College Way Surgery, Comeytrowe Centre, Taunton. Somerset. TA1 4TY; is located just off College Way, close to the town centre of Taunton. The Practice area includes all of the following geographical areas. Roughmoor, Upcott, Rumwell and Bradford on Tone to the North. Trull, Wilton HillbrookMiddle Stoford, West Buckland, Hamwood Diptford, Sweethay and Kibbear to the South West. Diddlestone Fulwood Pitminster Blagdon Hill, Howleigh Budleigh and Buckland Farm South of the M5.

The practice is part of the Taunton Deane area Federation of GP Practices and has approximately 12,500 patients. The facilities provided by the practice include 13 consulting rooms, four treatment rooms, a phlebotomy room (for carrying out blood tests in). There is level access into the practice and to all patient accessible areas; toilets are accessible with facilities for patients with disabilities. Parking is available on site and close to the practice. There are a range of administrative and staff areas including a training area within the practice. The practice is a registered GP training location.

There are nine partners in the practice. One of the GPs works full time and eight work part-time. Each GP holds a patient list and has a 'buddy' GP who knows the patients of their buddy. Four GP's are female and five are male. There was one male registrar GP also working in the practice. In addition there is a nurse manager, a senior practice nurse, three practice nurses, a phlebotomist and two health care assistants. The practice also employs a data manager, a team of reception and administrative staff including medical secretaries. These teams are supported by a reception manager and an assistant reception manager and a practice manager and an assistant practice manager.

The practice has a General Medical Services (GMS) contract to deliver health care services, the contract includes enhanced services such as extended opening hours. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This is provided by another organisation and patients are directed to this service by the practice during out of hours.

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.

Detailed findings

Please note that when referring to information throughout this report for example, any reference to the Quality and Outcomes Framework data, this relates to the most recent information available to the CQC at that time.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 25 November 2014.

We talked with the majority of staff employed in the practice. This included eight GPs and a registrar GP, the nurse manager, two practice nurses, a health care assistant, the practice manager and their deputy, the reception manager and six administrative/reception staff. We spoke with six members of the patient participation group, eight patients visiting the practice during our inspection and received comment cards from a further 22 patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, where incorrect system read codes had been entered onto a patient record. This had been identified by another staff member and reported to their immediate manager. The subsequent actions taken ensured the correct codes were communicated to all relevant staff and applied to the records to avoid the incident recurring.

We reviewed safety records, incident reports and minutes of management meetings where these were discussed for the last year. These showed the practice had managed the significant events and complaints consistently over time, had investigated thoroughly, and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we reviewed these. Significant events were a standing item on the management meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nurses knew how to raise issues for consideration at the meetings and told us they felt encouraged to do so.

Staff used incident forms or emails on the practice intranet and sent completed documents to their immediate manager or the practice manager. They showed us the system they used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result for example, updated medical alerts on patient notes and more thorough checks for historical test results. Where patients had been affected by something that had gone wrong, the practice policy was that they were invited in to the practice to discuss what had happened, given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the senior partners and the practice manager to practice staff. Staff we spoke with gave examples of recent alerts that were relevant to the care they were responsible for. They also told us and we saw from meeting minutes provided to us that alerts were discussed in management and continuous professional development (CPD) meetings. This ensured all staff were made aware of those relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed dedicated GPs with lead responsibility for safeguarding of vulnerable adults and children. They had been trained to level three for child protection and separately for vulnerable adults and could demonstrate they had the necessary training to enable them to fulfil this role. The records for training received by other GPs did not indicate that training had been completed to level three in safeguarding children. However, all staff we spoke with knew who the lead staff were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans and families currently living in

Good

Are services safe?

parenting observation and support units (a location where family interactions are monitored and assessed). Similar arrangements were available for older patients with severe dementia and for patients on the 2.5% most vulnerable patients list (a list kept by GP practices of their most vulnerable patients and those most likely to be admitted to hospital).

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. This information was available in nine different languages, including Polish, which was the main other language spoken locally. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, all receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We saw the policy did not cover all eventualities, for example if the GP had to leave the room leaving the chaperone alone with the patient. The practice manager told us they would amend the policy so it included these points.

The practice had identified children, young people and families living in disadvantaged circumstances, including looked after children and young carers. Young carers had been given GPs direct line telephone numbers so they could contact them for support, advice and information about other sources of support. There was a system for identifying children and young people with a high number of A&E attendances. A regular report was provided to the practice and these reports were reviewed and discussed by the GP partners. Information from these meetings was shared with health visitors and community teams which ensured patient safety. Alerts were recorded on the system to notify GPs of this during routine appointments.

The practice had a system in place which ensured patients including, the elderly, families, children and young people and vulnerable patients had reviews where they were diagnosed with co-morbidities (two or more diseases existing at the same time in the body) or took multiple medicines. These reviews took place quarterly or when the patients condition changed. We heard how all GPs were aware of the patients on the practices list of most vulnerable patients. All care plans for patients on this list were reviewed in line with changes in their conditions or circumstances.

Medicines management

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

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

All GPs and nurses who administered flu vaccines in a dedicated clinic were allocated a clerical officer to do the routine administration associated with vaccinations. This allowed the GPs and nurses to spend more time with the patient and speed up the processed. We saw up-to-date copies of directions and evidence that nurses and GPs had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. 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 controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

However these medicines were very rarely used and were often out of date and disposed of before they were required. We raised this with the practice, who planned to remove these medicines as they were unnecessary.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance and kept securely at all times.

Cleanliness and infection control

Good

Are services safe?

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The nurse manager had lead responsibility for infection control. They undertook further training which enabled them to provide advice on the practices' infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the nurse manager had carried out audits this year and that any improvements identified for action were completed on time. They also carried out monthly practice spot checks to ensure policies were being adhered to. Minutes of practice meetings showed that the findings of the audits and spot checks were discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy, for example, during intimate patient examinations or minor surgery.

There was a policy for needle stick injury of which staff were aware. There had been two needle stick injuries recorded in the accident book. We saw that the policy had been followed in regard of these accidents. However we saw that the record of hepatitis B immunity had not been maintained and did not reflect the current status for all staff.

Notices about hand hygiene techniques were displayed in staff and but not in patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had sufficient equipment which enabled them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested, recalibrated and maintained regularly and we saw equipment maintenance logs, dated stickers on plugs and equipment, and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, blood pressure monitoring equipment, weight monitoring scales and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that recruitment checks had been undertaken prior to employment for the majority of staff. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). However two staff we spoke with, who had been employed prior to the practice being required to register with the Care Quality Commission, had an existing DBS or Criminal Records Bureau (CRB) certificate from a previous employer, and new checks had not been made to see if the certificate had been amended.

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

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

We heard about how the practice used an 'internal locum' system to cover GP and nurse absences. This was possible as most GPs and nurses worked part time and could work

flexibly to cover absences. Patients benefitted from this arrangement as they received continuity of care from a staff team who knew them. A similar arrangement was in place in the reception and administration teams where all staff received training in different roles to enable them to cover other staff.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place which managed and monitored risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log and business continuity plan. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw staff identified and responded to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of care plans with clearly identified care pathways and referrals to consultants or other services made for patients whose health deteriorated suddenly. There were emergency processes in place for identifying acutely ill children and young people and staff gave us examples of referrals made for example, a child diagnosed with asthma who developed chronic breathing problems.

Emergency processes were in place for acute pregnancy complications, these were achieved as the practice staff worked closely with the midwife and health visitor services.

Staff gave examples of how they responded to patients who experienced a mental health crisis or who were drug and alcohol users. This included supporting them to access emergency care and treatment. Referrals were made to a range of local services including Talking therapies, MIND, community mental health teams and Alcoholics Anonymous.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses the life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm.

When we asked members of staff if they all knew the location of this equipment. They told us it was located in the treatment room. Records we looked at confirmed that it was checked regularly by the nurse manager. The notes of the practice's significant event meetings showed that staff had discussed medical emergencies concerning patients and that practice had learned from these appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of acute pain, cardiac arrest, epileptic seizures, anaphylaxis and hypoglycaemia. We were assured by the nurse manager that a full risk assessment had been undertaken and a protocol was in place to manage this for example, reception staff would alert all staff using an emergency button, GPs and nurses would manage the patient, office managers would dial 999 for emergency services and manage patient privacy. Significant event recording and staff we spoke with showed these events were well managed. Processes were also in place to check 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. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness, access to the building and complete loss of the building. In the last example arrangements had been put in place to temporarily locate the practice in a local school. The document also contained relevant contact details for staff to refer to. For example, contact details of the electricity company to contact if the power system failed.

Good

Are services safe?

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Fire equipment such as fire extinguishers was observed to be regularly serviced and maintained.

Risks associated with service and staffing changes, both planned and unplanned, were required to be included on the practice risk log. We saw an example of this where the practice used an 'internal locum' system to cover GP and nurse absences and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The patients we spoke with during our inspection told us the treatment they received helped improve or maintain their health and the quality of treatment met or exceeded their expectations. These comments were corroborated by the surveys carried out by the practices patient participation group (PPG) and the most recent NHS GP survey.

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

The GPs told us they had lead roles in specialist clinical areas such as coronary heart disease, dermatology, neo natal checks, dementia, vasectomy and asthma and the practice nurses supported this work particularly in regard to long term conditions. These lead roles allowed the practice to focus on and advise each other about specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of dermatological disorders. Our review of the clinical meeting minutes confirmed this happened.

One of the GP partners showed us data from the local federation of the practice's performance for antibiotic prescribing, which was comparable to similar practices locally. The practice had also completed a review of case notes for feverish illness in children which showed all were receiving appropriate treatment and were regular reviewed but that recording of investigative pathways required improvement. This had been shared with the GPs and improvements were being monitored ahead of a subsequent audit.

The practice used computerised tools to identify patients with complex needs and who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within a week by their GP according to need. Other reviews were carried out opportunistically during routine appointments.

National data showed that the practice was in line with or better than referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with suspected cancers. They were seen by two GPs in the practice who specialised in cancer care and were referred and seen within two weeks. Biopsies and minor surgery for dermatological conditions were carried out in the practice. The practice also treated patients referred from other local practices. Patients visiting the practice told us these interventions were preferred and the practice told us the treatment had helped reduce hospital referrals.

Patients were not discriminated against when GPs and nurses made care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

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, reviewing minor operations, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us 12 clinical audits that had been undertaken in the last two years. All but one had been completed. The practice was able to demonstrate the changes resulting since the initial audit. For example, auditing patients prescribed with a combined oral contraceptive pill (COCP). This resulted in a change of

protocol for obese patients. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and NICE guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and the outcomes framework (QOF). The QOF is a national performance measurement tool. For example, we saw an audit about records quality. Following the audit, the GPs discussed ways to improve recording and used a benchmark example to inform future record keeping. A further audit had been planned to document the success of any changes.

The GPs and nurses made use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with told us they collectively discussed how they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice about audits and quality improvement.

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

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. Patients on the palliative care register were included in the practices most vulnerable patients list. As a consequence of staff training and better understanding of the needs of patients, the practice had increased their number of most vulnerable patients to 2.5% of the patient list.

The practice also participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or better than other services in the wider CCG area. For example in the reduction of hospital admissions, the palliative care register and multidisciplinary care meetings.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We saw a good skill mix among the GPs with seven having additional diplomas in sexual and reproductive medicine, three with diplomas in family planning and two with diplomas in dermatology. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example annual updates for emergency first aid, safeguarding vulnerable patients, infection control and health and safety. As the practice was a training practice, GPs registrars who were training to be qualified as GPs were offered extended patient appointment slots and had access to up to three senior GPs throughout the day for support. We received positive feedback about the practice of nurses and GPs as well as how the practice was managed from the trainees we spoke with.

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

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

The practice worked with other service providers to meet people's needs and manage complex patients with co-morbidities (two or more co-existing conditions or diagnoses). It received test results, X ray results, and letters from the local hospital which included discharge summaries. Communications were also received from the out-of-hours GP service and the 111 service both electronically and by post. The practice had a policy which outlined the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy which ensured action following hospital communications worked well in this respect. The practice regularly monitored patients who had been discharged from hospital.

The practice held multidisciplinary team meetings at least every three months to discuss the needs of patients with complex needs. For example those with end of life care needs, patients with a learning disability or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. Staff told us they felt this system worked well as a means of sharing important information and planning effective patient care.

Information sharing

The practice used computer based systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider which enabled patient data to be shared in a secure and prompt way. Computer based systems were also in place for making referrals and the practice made the majority of referrals through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For patients who required emergency treatment, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The GPs we spoke with told us how straightforward this task was using the electronic patient record system. They highlighted the importance of this type of communication with A&E to ensure patient safety and effective patient outcomes. The practice has also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours). We saw from posters and other information that patients were invited to opt out of this programme if they did not want information shared.

The practice had systems in place which provided staff with the information they needed. Staff used an electronic patient record, INPS Vision, to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's security and ease of use. The software enabled scanned paper communications, such as documents from hospital, to be saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

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

Patients with a learning disability and those with a diagnosis of a dementia were supported to make decisions

through the use of care plans, which they were involved in and agreed to. These care plans were reviewed annually or more frequently if changes in their diagnosis or condition were identified. The practice kept records which showed all care plans had been reviewed at least once in last year. The staff we spoke with gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes. The notes also included a record of the relevant risks, benefits and complications of the procedure. We were shown an audit that confirmed the consent process for minor surgery had being followed in the majority of cases.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the clinical commissioning group (CCG) and the Taunton and Dean federation to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity such as smoking cessation and leading more active lives.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients who registered with the practice. The GP was informed of all health concerns detected and these were followed up in during routine appointments. We identified 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 opportunistic chlamydia screening to patients aged 18-25, offering smoking cessation advice to smokers and by encouraging patients to self-refer to services such as talking therapies to support their emotional wellbeing.

The practice also offered NHS Health Checks to all its patients aged 40-75. GPs told us they offered these checks when patients in this age range came in for routine appointments. A GP showed us how patients were followed up the same day if they had risk factors for disease identified at the health check and how they scheduled further investigations or consultant appointments.

The practice had a range of 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 physical health check. Practice records showed all had received a check up in the last 12 months. The practice had also identified the smoking status of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 85%, which was better than the national average and in line with other local practices. There was a process to offer telephone reminders for patients who did not attend for cervical smears with a named nurse responsible for following up patients who did not attend screening.

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 all immunisations was in line with other practices in the CCG. There was a clear process for following up non-attendance for immunisations by the named practice nurse.

The practice kept a register of patients who were identified as being at high risk of hospital admission, had a diagnosis of dementia, or who were nearing the end of their life. Up to date care plans were completed and shared with other providers such as the out of hours service. Three monthly multidisciplinary case management meetings took place and care plans were updated. All patients over the age of 75 had a named GP and for those who lived in residential or nursing home there were two named GPs who made regular visits.

The practice had system alerts for particular needs such as older patients who had difficulties with mobility, vision and hearing. Flexible appointment times including 20 minute appointments were available to older patients and other vulnerable groups if required. Some patients with

Good

Are services effective?

(for example, treatment is effective)

particular needs, for example those with dementia, automatically defaulted to 20 minute appointments and an alert was added if patients needed to be seen by their named GP during open surgeries.

Carers details were recorded including special messages where appropriate. There was clear documentation of consent to allow the GPs and nurses to discuss problems with carers and relatives if appropriate. Staff had been trained to recognise particular patient needs and to alert GPs immediately of any concerns for example, chest pain, shortness of breath or undue distress. Patient care was tailored to individual needs and circumstances but took into account patient and carers values, expectations and choices. The practice recognised the importance of carers and support was offered to them as appropriate.

Older patients with more complex needs and who were at risk of unplanned hospital admissions all had care plans in place. These were reviewed at regular multi-disciplinary team meetings. Unplanned admissions were monitored and discussed. A named member of staff contacted all these patients after discharge from hospital and alerted GPs of any concerns. Read codes were on the patient record to indicate carers, door access codes and drug nomad trays.

Patients with long term conditions such as diabetes, heart failure of multiple conditions received regular and annual reviews. Patients with diagnosed diabetes received regular monitoring and had access to an annual foot check and could be referred to a local chiropody service. Basic eye testing was provided in the practice with patients being referred to other services for more detailed checks. Where health promotion and lifestyle advice was offered to patients this was recorded in the patients notes. Where the patient was at risk of unplanned hospital admissions due to their long term conditions they were included in the list of most vulnerable patients and had their diagnosis regularly reviewed.

All patients with long term conditions had a named accountable GP. Care was tailored to individual needs and circumstances with regular reviews if necessary prompted from repeat prescribing system and formal recalls. This included patients who required international normalized ratio (INR) blood tests and high risk drug monitoring. Disease management clinics were run by multi-skilled nurses and included, diabetes, asthma and chronic obstructive pulmonary disease (COPD). The practice operated a formal appointment recall system for patients in these groups.

We heard about proactive case management aided by a named GP who reviewed all test results and prescriptions. Home diabetic checks and flu vaccinations were provided for housebound patients. Flexible access to services including same day appointments, same day telephone consultations and flexible disease management clinics were also available.

Patients with long term conditions were signposted to appropriate patient groups and support networks. Following patient feedback from the last patient participation group survey the practice had commenced a series of educational events for patients. These events provided more information about various conditions and enabled patients with long term conditions to be better informed about their conditions. The most recent event provided patients with information about diabetes and was well received by those who attended.

Families, children and young people were supported by a range of practice services. Immunisation rates for all standard immunisations were either in line with, or better than the local area average with 100% completion for some illnesses for example, infant meningococcal vaccinations.

All patients have named GP and all families were registered with same GP to assist with continuity of care. There were ‘front desk’ alerts for known children and families in need. Regular multi-disciplinary team meetings took place with health visitors to discuss children with protection plans and known to be at risk. GPs and nurses provided support for families at a local family assessment centre. Regular child protection training was provided for all staff which included early identification of need or risk. Patients were encouraged to access early help where needed with referrals to appropriate local services.

Reception staff had been trained to identify acutely ill children, these were offered immediate telephone consultations with a GP and/or an urgent as soon as possible appointment as appropriate. A midwife and health visitors worked from the practice which aided close joint working.

Young people were offered appointments with a female or male GP if requested with no questions asked. They were

Good

Are services effective?

(for example, treatment is effective)

provided with contraception advice, sexual health advice and contraception medicines including, intrauterine contraceptive devices, implants, vasectomy and emergency contraception. Same day appointments were provided for discussions about emergency contraception. School leaver immunisation sessions targeted contraception health promotion.

Regular child immunisation clinics exceeded all national targets. Children and young people were treated in an age appropriate way and were recognised as an individual with their preferences considered. The practice provided medical officers for boarding pupils at a local private school with twice weekly surgeries there.

We saw information was available which sign posted young people towards sexual health clinics and posters offered more information about extra services such as contraception advice. Chlamydia testing packs were available in the practice. We saw evidence of multi-disciplinary team working through GPs and nurses having special interests in these areas of sexual health. One GP provided vasectomy advice and held regular minor surgery clinics in the practice.

Working age patients had access to a range of appointments outside of normal practice times. These appointments included late evening and weekend appointments. These could be booked via an online facility or by telephone. Health checks were offered when these patients attended routine appointments as were cervical smears and blood pressure checks. The practice provided a range of lifestyle information for this group of patients including how to get support for managing stress at work, depression and other mental health problems.

Flexible appointment times including same day telephone consultations were available to working age patients. The practice routinely saw patients from 8.30 am and had extended hours Monday to Friday. Constant monitoring of the appointment system provided additional appointments if needed and in-house locums were booked where demand exceeded planned appointments.

A range of additional in-house services including, phlebotomy with centrifugation (a process of separating samples for later processing) of samples when needed, electrocardiograms (ECGs), spirometry (a test that can help diagnose various lung conditions), ambulatory blood pressure monitoring (a non-invasive method of obtaining blood pressure readings over a 24-hour period), international normalized ratio (INR) blood tests monitoring and NHS health checks.

When referrals were required we heard from patients that full patient choice was offered via the Choose and Book system. On-line prescribing and appointments had been introduced and the practice was currently working towards e-prescribing.

Patients whose circumstances may make them vulnerable were identified on a register in the practice. The list included those patients from various vulnerable groups for example, patients with learning disabilities and children from outside the area living in family observation units. All patients with diagnosed learning disabilities received annual follow-up appointments and regular health checks. Children from outside the area living in family observation units were registered as temporary patients along with their parents so they could access a GP.

Those patients in the 2.5% most vulnerable group were reviewed by multidisciplinary teams which ensured the most effective care and treatment was provided and care plans were updated. These patients were also provided with information about various local support groups and voluntary organisations such as those who provided community therapy services and speech and language therapy.

The practice operated a ‘no barriers’ policy for patients who wished to access a GP and included immediate necessary registration when appropriate; this included those with no fixed abode. These patients were encouraged to participate in health promotion activities such as breast screening, cytology and in-house smoking cessation clinics. Patients were able to access the practice services without fear of stigmata or prejudice and a translation service was available.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Services (CAMHS) and Adult mental health services. We saw evidence that elderly patients with a diagnosis of dementia had advance care planning in place as well as referrals to speech and language therapists and psychological

Good

Are services effective?

(for example, treatment is effective)

services. Carers of these patients were identified and referrals were made to a local carers organisation to enable them to receive support if they required it, as well as the Carer's National Association.

A named accountable GP was available to patients who experienced poor mental health with flexible appointment times including same day emergency appointments and telephone consultations. Staff were trained to be sensitive to patients distress and to offered extended appointment times when appropriate. GPs were informed immediately of any undue distress being shown by patients.

The GPs told us the practice had good working relations with an accessible local Crisis Team and could book same day assessments for patients in need of prompt interventions. Records showed there were annual reviews for patients on the mental health register. The annual review included help and support for carers. The practice used review appointments to encourage health promotion.

Counsellors were available within the practice which helped improve communication with patients. Care was tailored to individual needs and circumstances.

The practice had worked towards being a dementia friendly practice. The entire practice staff team having received training from the attached pharmacist who is a Dementia Champion.

The practice provides GP support for seven residents at a local unit for people with learning disabilities. All patients there had a named responsible GP. The records of those patients with learning disabilities were clearly flagged to alert GPs to the additional communication needs of the patient. Some patients with particular needs automatically defaulted to 20 minute appointments and an alert was added if patients needed to be seen by their named GP during open surgeries. All patients on the learning disability register were offered an annual review to assess their needs and encourage all aspects of health promotion as appropriate.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey, a survey of 246 patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. The evidence from all these sources showed patients were very satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' (92.3%) for patients who rated the practice as good or very good. The practice was also well above average (97%) for its satisfaction scores on consultations with GPs and nurses with 93% of practice respondents saying the GP was good at listening to them and 94% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 22 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. One comment was slightly less positive but the comment was about the NHS generally rather than the practice. We also spoke with 14 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected at all times during appointments.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located in a separate area of the practice from the reception desk which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This helped prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and saw it enabled confidentiality to be maintained. Separate rooms were available if patients wished to speak with practice staff in private.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us they would investigate concerns raised and any learning identified would be shared with staff. No incidents of this type had been reported.

There was a statement to patients stating the practice's zero tolerance for abusive behaviour on the practice's website and in the waiting area.

Our expert by experience spoke with spoke with six members of the patient participation group, eight patients visiting the practice during our inspection and received comment cards from a further 22 patients. All the comments made by patients stated they were treated by a caring and professional practice team who treated them with dignity and respect. They told us their privacy was maintained at all times and their human rights were respected.

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 75% of practice respondents said the GP involved them in care decisions and 84% felt the GP was good at explaining treatment and results. Both these results were slightly below average compared to CCG area but were not reflected in the individual comments from patients during the inspection.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and

Good

Are services caring?

supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and corroborated these views.

Staff told us that translation services were available for patients who did not have English as a first language. Notices in the waiting areas informed patients about translation services. We also saw notices in the reception and consulting areas in nine different languages informing patents that a chaperone service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, two patients told us about how they were provided with access to emotional support services. One patient told us about access to a self-referral counselling service whilst another told us about GPs giving their personal telephone numbers to young carers so they could access guidance and support. The patients we spoke to on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted how staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw the leaflets and booklets available for carers to ensure they understood the various avenues of support available to them. The practices website also provided carer information and links to other organisations.

Staff told us that if families had experienced a bereavement, their usual GP contacted or made a home visit to them. These contacts were either followed by a patient consultation or additional telephone contacts to offer them advice about support services or to listen to the patients concerns. Members of the patient participation group we spoke with confirmed this type of support normal practice and said they found it comforting and helpful.

Good

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 patients needs and had systems in place which maintained the level of service provided. The needs of the practice population were understood and systems were in place which addressed identified needs in the way services were delivered.

The NHS Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices and discussed local needs and service improvements that needed to be prioritised. We saw minutes of meetings where improvements had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. These included; to develop strong GP localities (known locally as federations), making sure locally commissioned health services reflect the needs of local communities, to put the patient at the heart of everything we do and make patient safety everyone's top priority, deliver integrated services where people can experience care closer to home, providing excellence to those with complex needs, to commission services which encourage patients with long term conditions to better manage their health through self-management and self-care, to promote health and wellbeing in Somerset and work with partner agencies to reduce health inequalities. We will work in collaboration with county and district councils, encouraging people to make healthier choices in their lives, to use our resources wisely, delivering the best possible value to the tax payer and to commission services collaboratively to ensure the best quality and outcomes for patients. This Somerset Clinical Commissioning Group vision was embedded in the practices work philosophy and in the practices vision statement. Involvement by GPs and the practice manager in the Taunton and Deane Federation demonstrated their commitment to these aims.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included, providing education events for patients, considering a revised reception layout and considering what services could be improved. A detailed action plan had been produced and many improvements had been made.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, patients who did not speak English as a first language and who requiring a chaperone during an appointment had information about this facility in nine different languages. The practice had access to online and telephone translation services. A hearing loop system was available in the practice to support patients who used hearing aids to assist their communication.

Two named GPs made regular visits to patients who lived in local residential or nursing homes. Patients with no fixed abode could register with the practice and have access to a GP and other practice surgeries. All patients were encouraged to participate in health promotion activities such as breast screening, cytology and in-house smoking cessation clinics.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training during their induction period and that equality and diversity was regularly discussed at staff appraisals and meetings.

The premises and services were adapted to meet the needs of people with disabilities with level access, wide corridors and thresholds and accessible toilet facilities.

The practice actively supported people who have been on long-term sick leave to return to work and provided access to counselling services, referral to physiotherapy services, 'fit notes' and lifestyle guidance and support.

The practice was situated on one level with all services for patients on this level. The practice had provided turning circles in the wide corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

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. However chairs provided for less able patients took up the space provided previously for wheelchairs. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

The practice had a population of approximately 96% English speaking patients though it could cater for other different languages through translation services.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Access to the service

Appointments were available from 8:30 am to 6:30 pm on weekdays. Additional appointments were available after 6:30 pm each weekday by appointment with a priority for these appointments for patients who worked. The practice closed for an hour each Wednesday lunchtime to allow team meetings and training to take place. Two open surgeries were provided each day at 11:30 am and 5:20 pm to allow patients to be seen without appointments, all GPs were involved in these surgeries.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements which ensured 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-hours service was provided to patients. This information was also on the practices website.

Longer appointments were available for people who needed them and those with long-term conditions or multiple problems. Appointments were available with a named GP or nurse. Home visits were made to local care homes by two named GPs and to those patients who needed home visits. A report made by the practice about clinical consultations during our inspection day showed they provided 270 GP and nurse face to face consultations, telephone consultations and home visits. This rate of appointments could result in over 90,000 appointments being available for patients each year, or seven appointments for each patient registered with the practice.

Patients were generally satisfied with the appointments system. The practice had adopted a call centre approach to their telephone booking system with 12 lines available for incoming and outgoing calls. The main system had been connected to a flow monitoring system to manage the flow and distribution of calls. A visual display system allowed the reception manager to constantly monitor how promptly calls were responded to and to add extra telephonists to help manage peak demand. The types of call were monitored so that future resource management could be planned. Through our contacts with the practice and our observations during the inspection we saw that calls were managed promptly

Patients confirmed that 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. For example, one patient we spoke with told us how they had telephoned the practice that day and had been provided with an appointment.

The practice's extended opening hours each day were particularly useful to patients with work commitments. This was confirmed by patients we spoke with and by representatives of the patient participation group. Where patients lived in local residential or nursing homes the home managers had direct dial telephone numbers which enabled them to access GPs to discuss urgent concerns.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. Summary leaflets were available and information was available on the practices website. Comments and suggestions were also encouraged in the waiting areas. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at five complaints received since the start of the year and found all had been managed in line with the practices complaints policy. The complaints had been dealt with in a timely way and the practice had been open and transparent when dealing with the complaint. We saw patients had been sent apologies or had been invited into the practice to discuss the events leading to the complaint. The practice reviewed complaints regularly to detect themes or trends. The outcomes of these reviews were discussed at monthly meetings and lessons learned from individual complaints had been acted on.

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. We found details of the vision and practice values were part of the practice's strategy and overall business plan. These values were clearly displayed on the practices website and in the practice and included, working together, being treated with courtesy and respect, being treated by a suitably qualified person, promoting good health through advice and preventative medicine, and being seen promptly.

The patients we spoke with confirmed the practice provided services in the way their values were described.

All the members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on any computer within the practice. We looked at eight of these policies and procedures and most staff had completed reading these as part of their induction to the practice. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and senior partners had lead responsibility for safeguarding vulnerable patients. We spoke with 25 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 practice meetings where governance had been part of the agenda. We looked at minutes from the last three meetings and found performance, quality and risks had been discussed.

The practice had measured their performance by using Somerset practice quality scheme (SPQS) data and the Quality and Outcomes Framework (QOF). All the data for this practice showed it was performing similarly with or better than the local and national standards. We saw practice data was regularly discussed at monthly business meetings and action plans had been produced to maintain or improve outcomes.

The practices nurse manager told us about a local peer review system they took part in with neighbouring GP practices. The practice had an on-going programme of clinical audits, for example, a weekly audit to ensure that all patients taking anticoagulant medicines attend their appointments, which it used to monitor quality and systems to identify where action should be taken.

The practice had robust arrangements to identify record and manage risks. The practice manager showed us their risk log which addressed a wide range of potential issues, such as loss of services, environmental problems and staff illness. We saw the risk log was discussed at meetings and updated in a timely way. Risk assessments had been carried out where risks had been identified and action plans had been produced and implemented. For example, extending the practice to accommodate more consultation rooms.

Leadership, openness and transparency

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

Administrative 'office' meetings were also held regularly to plan and deliver the practices services and to reflect on the positive work done by this team of staff. For example, at a meeting on 11 November staff were thanked for their dynamic and flexible commitment in and around the reception area of the practice. Other subjects discussed included, managing patient discharge summaries, completing spreadsheets, medical reports and new patient cards. The minutes showed these meetings were well attended.

Are services well-led?

Good

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

The practice also provided a simple online 'message book' to pass on key practice information, instructions about work which required completing, training opportunities and important information which affected patients. Staff signed the 'book' to say they had read the messages and checks were made by the reception manager to ensure all staff had read the information.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment policy, induction policy for different staff roles and management of sickness which were in place to support staff. We were shown the computer based information that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

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

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, family and friends surveys, the practices patient participation group (PPG) and comments and complaints received. We looked at the results of the annual patient survey and saw 70% were satisfied with the level of privacy when speaking to receptionists at the practice. We saw as a result of this the practice had introduced a queuing system to improve this area of the practice. The reception manager showed us improvements had been made to the waiting area, which included a separate prescription window and planned new seating and redecoration.

The practice had an active patient participation group (PPG) which has steadily increased in size with over 30 active members. The PPG included representatives from various population groups; including young families, the working population, recently retired and older people. The PPG had carried out annual surveys and met three or four times a year or more frequently if required. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and that they had staff training sessions weekly where guest speakers and trainers attended.

The practice was a GP training practice with one registrar GP in post at the time of our inspection. The registrar had extensive experience in hospital medicine and was spending a year with the practice to gain experience in family medicine. The registrar told us they were supported by up to three GPs in the practice and could always access a GP for advice or opinion. They told us about the useful practice intranet system and the information it provided as well as other resources available to them for example, journals and health publications. They were very complimentary about the support they received and the way the practice was managed when compared to colleagues in other practices.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings this ensured the practice improved outcomes for patients.