Harbourside Family Practice

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Harbourside Family Practice on 24 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, responsive and effective services and for being well led. It was also good for providing services for the all the population groups. However we found that the practice required improvement for providing safe services specifically for staff recruitment.

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

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- 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

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including

- The practice works in an integrated way with other service providers, for example they are taking part in a pilot with the local community partnership Elderly Care and Referral Advice Service.
- The practice had implemented the 'You're Welcome' quality standards for young people and had worked closely with the local schools to improve the website and presentation of health promotion information I the waiting room so as to appeal to younger patients.
- Practice staff had signed up to the 'Dementia Friends' initiative.

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

Importantly, the provider must:

- Ensure that the staff recruitment process is applied to all staff and protect patients to mitigate against the risks of the employment of unsuitable staff.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for safe. We found the practice had systems, processes and practices in place to keep people safe and these were communicated to staff. Staff understood their responsibilities to raise concerns and incidents. Safety was monitored using information from a range of sources. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. However the practice had not always followed a safe recruitment practice which could put patients at risk. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice also had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for effective. The practice demonstrated patients' needs assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate prescribed treatment. We found staff had the skills, knowledge and experience to deliver effective care and treatment. Patient's consent to care and treatment was always sought in line with legislation and guidance, such as written consent for insertion of subcutaneous medicines.

Are services caring?

Good

The practice is rated as good for caring. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. We were given examples of how the practice had gone over and above what was expected of the service. We observed a strong patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We were told by all the patients we spoke with they were treated as individuals and partners in their care. We were given examples of patient's making choices and being informed of the best care pathways for their treatment. We found the practice routinely identified patients with caring responsibilities and

Summary of findings

supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. It reviewed the needs of its local population and engaged with the NHSE Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found there was continuity of care, with urgent and routine appointments available the same day. Issues such as telephone access to the practice had been listened to and a new system sourced. The practice had excellent facilities and was equipped to treat patients and meet their needs. We found the practice was involved with providing integrated health services and embedded these in the local community services. The practice was responsive to changing risks including deteriorating health and wellbeing or medical emergencies. 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 was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality as its top priority. High standards were promoted and owned by all practice staff, and teams worked together. 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 and staff retention. The practice gathered feedback from patients via surveys. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. We found the practice worked collaboratively with community health services to support patients on the local 'virtual' ward with joint care planning and delivery.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Nurse led clinics were available to patients diagnosed with diabetes. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital had an individualised clinical note added to the GP out of hours provider's record managements system to share information and patient choice/preferences for treatment with other service providers.

Families, children and young people

Good

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

premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. For example, compliance with the national child immunisation programme was checked regularly by the nursing team. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments. We saw routine audits were carried out by the practice to highlight non-attenders for immunisations and other appointments.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered extended hours and online appointment. Flu vaccination clinics were provided on two Saturdays in October to increase availability to patients who worked.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability. It had carried out annual health checks for people with a learning disability and offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

The practice held a weekly clinic at a local nursing home for patients who were unable to attend the surgery. We heard from the staff there that patients had continuity of care from the visiting GP and they worked with the families to promote good health and well-being.

Summary of findings

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning for patients with dementia.

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

Summary of findings

What people who use the service say

We spoke with eight patients visiting the practice and we received 31comment cards from patients who visited the practice. 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 last Care Quality Commission inspection report about the practice undertaken on 18 February 2015.

The comments made or written by patients were very positive and praised the care and treatment they received. For example, patients had commented about seeing their preferred GP at most visits and about being involved in the care and treatment provided. Many patients had rated the service they experienced at the practice as excellent.

We reviewed the results from the latest national GP Patient Survey and found the responses did not confirm the experiences we heard from patients. The survey had found the proportion of patients who would recommend their GP surgery was 64% which was below the average for the Clinical Commissioning Group (CCG). We spoke with the practice about this and were reassured that at the time of the survey the practice had been experiencing staffing challenges but new staff had been appointed which had a positive impact on the service. The comments from patients and received on our comment cards expressed satisfaction with the service.

The latest national GP Patient Survey also identified that 81% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments and 85% of respondents say the last GP they saw or spoke to was good at giving them enough time. Comments we received from patients and other healthcare professionals confirmed that staff at the practice always listened to patients, and sometimes appointments were delayed to ensure patients had enough time with their GP.

The latest national GP Patient Survey found the practice consistently scored poorly on patient telephone access to the practice. This was also a theme from some patients who had completed comments cards. However we did not receive any critical comments about the care and treatment patients received from the staff at the practice. All of the patients we spoke with gave very positive feedback about the practice. Patients told us that they felt listened to and understood when they attended for consultations and treatment. Patients were very positive about the practice and overall interactions and experiences were described by some patients as excellent.

The practice had a patient representation group (PRG), the gender and ethnicity of group was representative of the total practice patient population. Information about the group was available on the website and in the practice. We spoke with patients who had been involved with the patient consultation groups who gave us examples of how closely they worked with the practice for service improvement. For example, we were told how the practice had asked them to 'test drive' the new telephone system before it was implemented for the whole practice. The group were positive about the impact they had for patients registered at Harbourside.

The practice had also commenced their current 'friends and family' survey.

Areas for improvement

Action the service MUST take to improve

Ensure that the staff recruitment process is applied to all staff and protect patients to mitigate against the risks of the employment of unsuitable staff.

Summary of findings

Outstanding practice

- The practice works in an integrated way with other service providers, for example, they are taking part in a pilot with the local community partnership Elderly Care and Referral Advice Service to combat social isolation amongst older patients.
- The practice had implemented the 'You're Welcome' quality standards for young people and had worked closely with the local schools to improve the website and presentation of health promotion information in the waiting room so as to appeal to younger patients.
- Practice staff had signed up to the 'Dementia Friends' initiative.

Harbourside Family Practice

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 special advisor, a CQC inspector, a nurse special advisor and an expert by experience.

Background to Harbourside Family Practice

Harbourside Family Practice is situated in the urban area of Portishead, North Somerset. It has approximately 9300 patients registered with a majority ethnicity of White British.

The practice operates from one location:

Harbourside Family Practice

Marina Healthcare Centre2 Haven ViewPortishead

The practice is made up of three GP partners and four salaried GP working alongside a nurse practitioner, four qualified nurses and two health care assistants (all female). The practice has a Personal Medical Service contract and also has some additional enhanced services such as unplanned admission avoidance. The practice is open on Monday to Friday 8am – 6.30pm for on the day urgent and pre-booked appointments. The practice had extended hours on Monday and Thursday between 6.30pm - 7.30pm and on Wednesday from 7am - 8am with extended hours for smoking cessation clinic appointments on Monday 6.30pm – 7.30pm.

The practice does not provide out of hour's services to its patients, this is provided by Bris Doc. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years old: 8%

5-14 years old: 13.8%

15-44 years 40%

45-64 years old: 24.45%

65-74 years old: 7.45%

75-84 years old: 4.27%

85+ years old: 2%

With 0.34% of patients in a residential or nursing home; the practice holds regular clinics at a local nursing home. Practice population ethnicity indicates a population of black and ethnic minorities to be 4.3%.

Information from NHS England indicates the practice is in an area of low deprivation with a lower than national average number of patients with long standing health conditions and caring responsibilities, and the practice population has high levels of employment. The patient gender distribution was male 49.46% and female 50.54 %; only female clinicians work at the practice.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the North Somerset Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We carried out an announced visit on 24 February 2015 2014 between 8.30am - 5pm.

During our visit we met and spoke with four of the GPs. We spoke with the nurse practitioner and two practice nurses. We also spoke with the practice manager and the reception and administration staff on duty. We spoke with eight patients in person (including a member of the PRG) during the day. We received information from the 31 comment cards where patients and members of the public had shared their views and experience of the service.

We observed how the practice was run, the interactions between patients and staff and the overall patient experience.

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)

Requires improvement

Are services safe?

Our findings

Safe track record

We spoke with four GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 24 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. These incidents included administrative incidents such as incorrect coding on the patient record, as well as clinical issues such as an incorrectly recorded blood result.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to the North Somerset Council about safeguarding issues.

We asked the lead partner how national patient safety alerts (NSPA) and other safety guidance was checked and circulated to the relevant staff. Although there was no clear protocol we found during our discussion with staff that safety alerts were circulated and acted on. Medicine and Healthcare products Regulatory Agency (MHRA) alerts may be included in a local prescribing newsletter received by all GPs. An email was circulated around the practice for discussion at the clinical meeting from which action such as a medicines search on the patient record system may lead to a letter to patients inviting them to attend for a review. Safety alerts and information was also available via the internet for staff to readily access. The practice manager told us how comments and complaints received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role.

We saw from summaries of the analysis of these events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example we reviewed 20 of the significant events and found that these were well written with clear learning points and actions. The minutes of subsequent SEA meetings evidence that there was a record of completion of the actions. There was a system of annual review of significant events and complaints for trends and risk areas.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and 'at risk' adults. We asked members of medical, nursing and administrative staff about their most recent training. We were told that non-clinical staff at the practice had been provided with or were in the process of completing training for both safeguarding 'at risk' adults and children. The practice worked with the local authority to access appropriate training. We saw evidence of the GPs and nursing having completed safeguarding training appropriate to their role. One GP took the lead with safeguarding children and for safeguarding 'at risk' adults at the practice. All of the GPs had been trained to level three for safeguarding children.

Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities. Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware who the leads were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. Regular

discussions took place with health visitors in regard to children identified as at risk. We saw minutes of meeting that evidenced regular multidisciplinary discussions with other health care staff where was clear that patients at risk were discussed and information shared appropriately with other staff at the practice. Care plans were in place for both children and adults.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms and on the website. There was a chaperone protocol for staff which set out clear steps staff should take and how chaperone support should be recorded in patient's records. Additional training through the clinical commissioning group had been provided to some of the administration and reception staff to provide chaperone support to patients. Patients told us they were aware of the availability of chaperones if they required it.

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 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. The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses had received appropriate training to administer vaccines. When nurses administered vaccines in the patient's own home, medicines to counteract any anaphylactic shock were always taken.

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. GPs bag checked and found they did not carry any medicines in GP bags, there was a specific emergency medicines bag for home visits; prescriptions pads were signed out to each individual GP and equipment in the bags was calibrated.

The practice had a GP who was the prescribing lead and they were able to describe the processes in place for reviewing prescribing at the practice. We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. The practice had commissioned a pharmacist to work with them one day a week to ensure the practice was following prescribing guidance. We saw several audits had been undertaken to ensure patient were prescribed medicines which worked affectively, for example, the practice had reviewed patients prescribed a certain type of eye drops which were being discontinued by April 2015. A number of research papers showed that the same medicine at a lower dosage had a very similar efficacy with a much lower profile of adverse reactions. It would be usual for the dispensing pharmacy to contact the practice to request a change in prescription. However as this can be time consuming and frustrating for the patient, the practice took a proactive approach and three patients were identified who are currently being prescribed the medicine and needed it to be changed. A letter was drawn up explaining the change of strength proposed and a brief explanation of the evidence found in the research papers. Patients had been asked to contact the surgery if they had any concerns. If appropriate, and agreed by the patient, the change will be implemented before the product is withdrawn in April 2015.

There was a system in place for the management of high risk medicines, which included regular monitoring which followed the national guidance. Appropriate action was taken based on the results. We saw the practice had audited their performance for prescribing anticoagulant therapy. We read the practice had set a target of 95 – 100% of patients achieving an appropriate level of control. For 2014 six patients (under 7%) were identified as not achieving a suitable level of control and were considered for alternative management. A patient who was achieving a suitable level of control only 19% of the time had been requested to book an urgent appointment with a GP to consider alternative medicines. Patients identified as not achieving an appropriate level of control between 40-50% of the time needed to be reviewed by their own GP to raise their awareness the alternative medicines.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely. We were told that printed prescription sheets remained in the printers overnight and this was a risk for the practice to address. There was a protocol for repeat prescribing which was followed the national guidance and implemented in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff that generated

prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure that patients' repeat prescriptions were still appropriate and necessary. This was overseen by the patient's GP so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any changes.

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 in a separate code locked key cabinet. There were appropriate arrangements in place for the destruction of controlled drugs.

Practice staff undertook regular audits of controlled drug prescribing to look for unusual products, quantities, dose, formulations and strength. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

Cleanliness and infection control

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 practice had a nurse with lead responsibility for infection control who had undertaken training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had carried out an audit in 2013 and that any improvements identified for action were completed.

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 including recording the immunisation status of clinical staff. For example, the storage and use of personal protective equipment including disposable gloves, aprons and coverings. These were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, when carrying out intimate patient examinations or taking blood samples. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection. Waste bins were foot operated in clinical area to maintain hygiene standards.

Staff were able to tell us about and show us the systems for safe disposal of clinical waste. The practice had a suitable contract with a clinical waste company.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).

Equipment

The practice was suitably designed and adequately equipped. The building, its fixtures and fittings were leased by the practice and as part of the agreement the landlord employed and specialist contractors as needed to maintain the building. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Other equipment such as fire extinguishers were also serviced and tested annually in line with fire safety requirements. Fire alarms and emergency lighting were also regularly tested and serviced to meet the recommendations for fire safety. The security alarm was also tested annually.

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms

to aid less mobile patients to stand; all appeared in safe condition. Adjustable examination couches were available in all treatment rooms which had appropriate privacy screening. There was a sluice area for the disposal of urine samples.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. For example, we saw that proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS) should be undertaken prior to employment. We were able to see staff files which contained evidence of the recruitment checks for the most recently recruited staff. We noted some files were incomplete and the practice could not evidence that the recruitment process had been followed in full for each member of staff. For example, some files did not contain any evidence that references had been sought. The evidence that all new staff had undergone a criminal record check was incomplete and the practice had not risk assessed staff to ensure they underwent the appropriate level of check. Staff confirmed to us that they received a comprehensive induction when commencing work in the practice. The practice had recruited a number of staff on a 'zero hour' contract but had not recruited or inducted them according to practice policy. In light of our findings the practice immediately stopped using staff who had not undergone the recruitment checks.

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. The practice had a policy of using a regular locum GP to ensure consistency of care was maintained as much as possible.

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. This was reflected in the comments made by patients about the staff at Harbourside Family Practice.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. 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. Cleaning materials were stored in way which met the Control of Substances Hazardous to Health (CoSHH) guidelines.

We saw that any risks were discussed within practice and team meetings. There were systems in place for monitoring higher risk patients such as those with long term conditions, in receipt of end of life care and patients being treated for cancer. Welfare, clinical risks and the risks to patient's wellbeing were discussed daily and weekly by the GPs and nursing staff. Patients who were identified as particularly vulnerable had a named GP and a care plan in place which specified potential problems and how the patient, in discussion with their GP, wished to be treated for them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told there was always first aid equipment available on site when the practice was open. We looked at the accident recording log book and found two recent accidents had occurred at the practice. Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. Staff knew where emergency medicines were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived. All staff had completed basic life support

Requires improvement

Are services safe?

training and were able to tell us the locations of all emergency medical equipment and how it should be used. Records confirmed that it was checked regularly. Emergency equipment was available including access to oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children.

Urgent appointments were available each day both within the practice and for home visits. We were told that the practice prioritised requests for urgent appointments for children. Out of hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help. 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 and access to the building. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out. For example, contact details of the power supplier.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. A fire risk assessment had been undertaken 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.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We were told by the GPs that the practice routinely used 'Medicine Map' which had up to date treatment protocols and referrals pathways which included the latest good practice guidance. 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 that staff completed thorough assessments of patients' needs in line with NICE guidelines. For example, we saw NICE guidance had been implemented by the practice in respect of having two 24 hour blood pressure monitors for patients to use at home to aid diagnosis and monitoring of hypertension.

The practice used an assessment tool to help identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid any crisis in their health. Patients with complex needs had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients in this category who were recently discharged from hospital were reviewed within 48 hours. This was monitored by the staff on receipt of discharge summaries, who ensured they were followed up by the most appropriate staff member.

The patients we spoke with told us about how GPs and nurses involved them in their care and treatment. They told us how the treatment they received helped them to get better or to maintain their health. 81% of patients involved in the national GP patient survey said the last GP they saw or spoke with was good at explaining tests and treatments to them and 74% said GPs involved them in decisions about their care. The practice operated a system of internal referral between GPs which allowed patients to be treated by a GP with additional knowledge of their condition. We saw this in process for minor surgery which was carried out by one GP . The practice also had one GP trained to use a dermoscope. This gave the patients the opportunity for patients to have skin exmainations throug a dermoscope for diagnosis of skin lesions without referral to secondary care.

The GPs told us they had lead responsibility for specialist clinical areas such as hypertension, contraception, NICE guidance, diabetes, heart disease and asthma. The practice nurses supported this work, by holding nurse led clinics run by the three trained nurses and the nurse practitioner. Patients who attended the practice with minor illnesses were assessed and treated by the nurse practitioner. Clinical protocols were in place and had been adapted by the practice to add value to patient care. For example the nurses at the practice had produced a protocol for the effective self-management of chronic obstructive pulmonary disease/bronchiectasis. This protocol took patients through three clear steps to self-diagnose and action any treatment. This had been introduced to patient at an organised educational session and had proved very successful.

GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. We observed the discussions between GPs and nursing staff about specific patients' concerns during the daily lunchtime meeting. The minutes of clinical and practice meetings confirmed that this happened.

The intelligent monitoring information we had available and that provided by the practice showed the practice had met or exceeded their targets for specific disease areas for the year 2013 to 2014. For example, it had met the target for the number of diabetics who had an annual foot examination, and patients with a serious mental illness who had a comprehensive, agreed care plan documented in their care record,

Discrimination was avoided when making care and treatment decisions. Interviews with GPs and other staff showed that the culture in the practice was in which patients were cared for and treated based on individual need. The practice took account of patient's age, gender, race and culture as appropriate.

Good

Are services effective?

(for example, treatment is effective)

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. We heard information from the Quality Outcomes Framework (QOF), significant events, new guidance and feedback from patients generated clinical audits. The QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for effectively managing some of the most common long-term conditions and for the implementation of preventative measures. The practice had an achievement rate of 99.2% of QoF targets for 2013-14.

The practice showed us a summary of clinical audits that had been undertaken in the last year. These were completed cycles of auditing and the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw patient on a medicine that required therapeutic monitoring and saw results of the monitoring tests had been audited with the result that patient who were stable had reduced monitoring. This meant they need to have less frequent blood tests. There was an expectation that the practice GPs should undertake part in at least one audit a year as part of their continuous professional development requirements.

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 to other services in the area. For example, the practice were fourth successful in the CCG for cervical cytology screening and the highest achiever for identifying atrial fibrillation prevalence.

The team was making use of clinical audit tools, clinical supervision and staff meetings to monitor the performance of the practice. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved particularly where there were incentives to do so. Staff spoke positively about the culture in the practice of involvement and how they could contribute to improvements to the service.

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

The practice had 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. The practice followed the North Somerset end of life framework which was based on the gold standard framework guidance for end of life care. When we spoke with the community nurses they told us that the practice was exceptionally good caring for patient at the end of their lives. We were told there were rarely any issues out of hours as the GPs had been effective in planning and implementing care which supported patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. Where there were gaps in training, particularly e learning, this was highlighted and planned for individual staff. We noted a good skill mix among the GPs with additional qualifications and specialist interest in a wide range of topics such as research and dermatology. This allowed for internal referral of patients to GPs with specialist skills and knowledge without needing to refer to secondary care. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We were informed GPs were provided with protected time for study leave each year. There was an ongoing plan of in house learning where guest speakers, joint training with other members of staff took place on a regular basis. The

Good

Are services effective?

(for example, treatment is effective)

nurse practitioner and practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, for administration of vaccines, cervical cytology and family planning.

We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisals identified learning needs from this action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the district nursing team.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. The practice had three patients in the community who were included in the 'virtual ward'. Regular meetings with other professionals such as the community matron, community nursing teams, health visitors, palliative care team took place. Staff felt this system worked well and there was a team approach to supporting their patients. We obtained positive feedback from the health care professionals who came in contact with the service. We were told they were a very friendly and open staff team who never failed to provide support to other professionals.

We heard how the practice worked with other health care providers in the area such as nursing homes to promote good health and well-being for patients.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Choose and book was facilitated on behalf of patients.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Summary Care records had been introduced to the practice in February 2015.

The practice also had an internal system which staff accessed for shared documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told that patients were supported to make their own decisions and documented this in the medical notes. Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. We were given an example of a patient who had an advanced care plan and how the GP had worked with the patient and family to ensure as far as possible all parties understood what this meant and that it was revisited and reviewed. The information received from the care home which was visited by the practice confirmed that the practice GPs involved patients and families in 'Do Not Attempt Resuscitation' decisions. We also read this information was recorded on the care plans of vulnerable patients.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions including a patient's verbal consent which was recorded in the electronic patient notes and written consent for minor surgical procedures.

Good

Are services effective?

(for example, treatment is effective)

We spoke with patients who confirmed that consent was asked routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patient's declined this was listened to and respected.

Health promotion and prevention

The practice had met with the local authority and the North Somerset Clinical Commissioning Group in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness. We noted the culture of the practice was to use their contact with patients to help maintain or improve mental, physical health and well-being. This was reflected by the information available to patients in the waiting room which had dedicated notice boards for specific topics. We were told that the practice had delegated to a member of staff responsibility to keep noticeboards up-to-date. We heard about the joint project the practice had with the local community Academy which identified the best way to display information to attract patient attention. We observed that recommendations had been implemented such as providing information about sexual health in a specific area alongside chlamydia testing kits. We were told that the practice had the highest return of these kits in CCG area at 41 %.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. New patients' health concerns were identified and arrangements made to add them into any long term health monitoring processes such as the diabetes, asthma or heart conditions clinics or reviews. The practice provided information and signposted patients to services which help maintain or improve their mental, physical health and wellbeing. For example, by offering smoking cessation advice to patients who smoke and accessing the North Somerset Council slimming clinics.

The practice identified patients who needed additional support. For example, the practice kept a register of all patients with a learning disability, all of whom were offered an annual physical health check. Similar mechanisms of identifying "at risk" groups were used for patients such as those receiving end of life care, and these patients were offered service support according to their needs.

The practice participated in the national screening programs such as those for cervical cancer. There was a process to follow up patients if they had not attended. The practice offered a full range of immunisations for children, travel vaccines and flu vaccines. We were told that flu vaccination clinics had been held at weekends to encourage children and families to receive the vaccination.

The practice staff were also involved in a project with a local community school promoting the practice and educating young people about their health. The practice provided social prescribing for health issues such as the North Somerset health walks fitness programmes and weight management.

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice.

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 for 2013, a survey of 282 patients with a return rate of 42%. The evidence from all this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 88% had confidence and trust in the last GP they saw or spoke to.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with eight patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients stated they felt GPs took an interest in them as a person and overall impression was one of wanting to help patients. We were given many examples of the GPs taking additional time to ensure patients received the care they needed such as making contact with patients outside of normal working hours and contacting secondary medical services to ensure referrals were received. All the patients we spoke with said they would recommend the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. In the treatment suite, where the nursing staff ran clinics, curtains divided the treatment couches and patients' privacy was maintained as best as possible when treatment was being carried out. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk to keep patient information private. The reception desk was also separated from the waiting room. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

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 74% of practice respondents said the GP involved them in care decisions and 78% felt the GP was good at explaining treatment and results.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Staff told us that telephone translation services were available for patients who did not have English as a first language. We saw the website had a facility for translation of information.

We found that the 2% of the population identified as vulnerable had their own care plan. We were told that the GPs acted as the care coordinator for a number of patients, all the plans had been reviewed. We found this provided a continuity of care and support for the patient because GPs could recall their patients and the particular circumstances, for example, if there was any local support or care. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions. For older patients, over 75, they had their own named GP.

Good

Are services caring?

Children and young people attending appointments told us they were treated in an age-appropriate way, and how GPs and nurses involved them in the consultation and acted on their preferences.

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, 97% said the last nurse they saw or spoke with was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this patient information. For example, these highlighted that staff responded compassionately towards carers and family members 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 were shown the written information available for carers to ensure they understood the various avenues of support available to them. A separate noticeboard had dedicated carer information, carer information booklets and a patient information file. We were told how access to appointments was flexible to patients who were carers, or had difficulty attending the practice because of their mental health needs. We were told how the GPs and health care staff were flexible to providing home visits to reduce the difficulties carers of patients had attending the practice. An example of the being home visits to patients and their carer for influenza immunisations

One of the staff acted as a carer's champion for the practice and the practice's computer system alerted GPs if a patient was also a carer. This meant that all carers were identified and sent relevant information about the monthly drop in clinic run by the local carer's organisation. The practice hosted representatives from statutory and voluntary agencies to these clinics to offer carers advice. Staff are registered as "dementia friends" and support staff to undertake training to be dementia champions.

Staff told us that if families had suffered a bereavement, the practice sent a bereavement card and made contact by telephone. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The patients and staff we spoke with on the day of our inspection and the comment cards we received gave examples of how the practice was caring towards its patients. We were given examples by staff not directly involved in patient contact of how they felt they were treated patients and the practice went over and above to ensure patients were safe and their needs met. For example, we were told about a patient who had experienced emotional stress and distress, and how staff had been able to support them until professional support had arrived. All of the staff we spoke with talked about the importance of the relationship they had with the patients.

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. There was also triage service so that urgent requests were assessed and requests were prioritised according to need. The practice had also looked at other methods of providing a responsive service by holding joint clinics with community services, such as the Lindsay Leg Club, to combat social isolation.

There was a computerised system for obtaining repeat prescriptions and patients used both the email request service, posted or placed their request in a drop box in reception or outside the building. Patients told us these systems worked well for them.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice. Representatives from the PPG said the practice listened to them about the comments patients made about the service.

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

The 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 changes to the appointments system as access to appointments at the practice and the online appointments system was unreliable. The response from the practice was to review how the on-line booking system was being used as well as the duty GP system to triage requests for urgent care. The members of the patient participation group we spoke with told us the practice responded well to issues raised.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice provided equality and diversity training as part of the staff induction.

The premises and services had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The services for patients were on the ground and first floor; however there was lift access to the first floor.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in residential or nursing home.

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

Access to the service

The practice is open on Monday to Friday 8am – 6.30pm for on the day urgent and pre-booked appointments. The practice does not provide out of hour's services to its patients, this is provided by Bris Doc. Information on the out-of-hours service was provided to patients. Appointments were available outside of school hours for children and young people. The practice had extended hours on Monday and Thursday between 6.30pm - 7.30pm and on Wednesday from 7am - 8am with extended hours for smoking cessation clinic appointments on Monday 6.30pm – 7.30pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

Patients told us they were aware that appointment times were not limited to ten minutes but lasted for however long was needed. This system was valued by patients although it meant that they may have had to wait beyond the time they expected. Patients were made also aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The feedback we received from patients was that they were very happy with the appointment experience; we heard that it was sometimes difficult to get through by phone.

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. One patient we spoke with had phoned the surgery and received an appointment for one hour later on the same day. The practice also had an online booking system for planned appointments.

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. The practice used the 'Patient-Chase' system which is a recall system for patients who required multiple annual reviews and avoided the inconvenience of multiple attendances for the patient. Home visits were made to a local nursing home by a named GP.

The practice and Patient Participation Group (PPG) told us they were aware of the delays in achieving appointments in a timely way for some patients. The issues about telephone access to the surgery had been ongoing; the practice had responded by funding additional lines into the surgery and purchasing a new telephone answering service. This service was available 24 hours a day and allowed patients to book or cancel appointments by telephone. This had been trialled by the patient participation group. We were informed that for patient who may have difficulties using the system there was additional support available to 'train' them. The practice had identified there was a high rate of non-attenders, or patients who did not show, which impacted on providing patients an appointment time of their choice. Both the PPG and practice team were looking at how they could reduce this and so better meet the demand for appointments at the practice.

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 looked at all the complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The practice took account of complaints and comments to improve the service, for example, complaints were discussed by the team so staff could contribute and learn.

We saw that information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take away if they wished to with details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately.

The complaints ranged from a variety of issues, some were in regard to staff attitude at the first point of contact at the reception desk. Others were in regard to patient expectation for treatment or referral to other healthcare providers. We saw that from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future.

There was a method to identify common areas of complaints. Each complaint or comment was also reviewed. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team.

We saw that information was available to help patients understand the complaints system in the waiting room and

Good

Are services responsive to people's needs?

(for example, to feedback?)

on the practices website. None of the patients we spoke with had ever needed to make a complaint about the practice but told us they felt the practice would listen and respond to their concerns.

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 work in partnership with patients to achieve excellence in care. We found information about the practice values in the patient leaflet and on the website. All the members of staff and they all knew and understood the vision and values and knew what their responsibilities and contributions were in relation to these. We looked at minutes of the practice 'Annual General Meeting' held in 2013 and saw there was a whole team approach to reviewing and planning the vision and values for the practice. Staff we spoke to told us they felt included in what changes happened and that any suggestions were welcomed by the management.

We observed from the presentation given by the practice at the start of the inspection that the practice were proactive in reviewing and implementing a strategy of improvement. The practice had identified areas which needed to improve titled 'What we think we could do better', and already started to formulate plans to move forward. For example, working in an integrated way with community services to set up a 'Lindsay Leg Club' for patients to reduce social isolation and improve healing rates for leg ulcers.

Governance arrangements

The practice held a regular series of meetings within the practice, for example, monthly partners meetings where issues were discussed and plans put in place to develop the service. We looked at minutes from a range of meetings and found that performance, quality and risks had been discussed. The practice had a number of measures in place as part of its governance arrangements for example, audits, procedures, reviews, monitoring mechanisms, questionnaires and meetings. These individual aspects of governance provided evidence of how the practice functioned and the level of service quality delivered to patients. The practice periodically looked at these as a whole using other indicators such as survey results, other forms of patient feedback, sudden deaths, diagnosis of new cancers and staff appraisals to provide an in depth review of service provision and shape their ongoing business management.

The practice had policies and procedures in place to govern how services were provided. These policies and procedures were available electronically, some in hard copy for easy access. Staff were required to record when they had read and understood new or reviewed policies and procedures. There was a system to ensure that policies and procedures were reviewed and updated where required on an annual basis. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals. Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. The practice also had a policy to follow for patients who made freedom of information requests. Staff we spoke to confirmed these they understood these topics and would be able to support patients.

The practice had arrangements for identifying, recording and managing risks. The practice manager addressed a wide range of potential issues, such as the environment. We found risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example within the infection control audit. The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Such as an audit of child protection procedures which reviewed records to ensure that all children at risk were identified on the patient electronic record system. This audit found that not all at risk children had been identified by the correct coding and action was taken to rectify the records. There was a reaudit to ensure that learning had been embedded into the team.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The member of staff who monitored performance told us about the regular checks undertaken to ensure that patients had received the reviews and tests they needed. We were told that if there were any deficits then the GPs and nurses would be made aware of this and action to remedy the situation would be taken. We also discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services. For example, the '**Avoiding Unplanned**

Are services well-led?

Good

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

Admissions' enhanced service meant the practice was proactive in identifying vulnerable patients, and ensured the care plans were in place and were reviewed.

Leadership, openness and transparency

We heard from staff at all levels that team meetings were held regularly for each area of operation and that the practice tried to hold a yearly 'Annual General Meeting' which all staff were expected to attend. Staff 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. Salaried GPs were included in meetings and this was reflected in the conversations we had with them where they felt included and valued in the running and development of the service. Staff shared a daily meeting after morning surgery and were available to share any concerns or issues.

The practice employed a practice manager to enable the business and administration of the service. Their responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of policies, for example the recruitment policy and induction programmes which were in place to support staff. We were shown the online staff information that was available to all staff. Those we spoke with knew where to find these policies if required.

The practice was proactive in planning for future needs; they told us they had planning for the maternity cover for one of the GPs. Recruitment processes had been followed for a replacement GP to ensure the practice could continue to deliver continuity of patient care. We were told about the future planning that had taken place to review and expand the minor illness clinics. The management team also had an away day booked which was intended to consolidate the team. Preparation for this had meant staff had to identify their team role using the Belbin team principles which assigned a distinct role to each member of the team and highlighted any skill deficits.This demonstrated the practice took and innovative approach to team productivity and improvement.

A GP partner held lead responsibility within the practice as the Caldicott Guardian and was clear about her role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place.

There was a clear leadership structure with named members of staff in lead roles. We saw this information was on noticeboards around the practice. All the members of staff we spoke with were all clear about their own roles and responsibilities and who to go to for support. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. There were GP leads for clinical governance, and the partners mentored salaried GPs.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, complaints received and the recently implemented friends and family questionnaire. The patient participation group (PPG) included representatives from various population groups; the working and recently retired and older patients groups. The PPG had carried out annual surveys and met quarterly. 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 also produced a quarterly newsletter available in the practice and on the website.

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

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

Management lead through learning and improvement

The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the North Somerset Clinical Commissioning Group (CCG), completing online learning courses and reading journal

Are services well-led?

Good

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

articles. Learning also came from clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan.

The practice had completed reviews of significant events, complaints and other incidents. Significant events were a standing item on the practice meeting agenda and were usually attended by the GPs, the practice manager and a practice nurse. Recent significant events were discussed and we were told by GPs they also reviewed actions from past significant events and complaints. There was evidence the practice had learned from these events and that the findings were shared. The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 21 HSCA 2008 (Regulated Activities) Regulations 2010 Requirements relating to workers **The registered person must operate effective recruitment procedures to ensure patients are safe and their health and welfare needs are met by staff who have the qualifications, skills and experience necessary for the work to be performed.**