

Frome Medical 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		Outstanding	☆
Are services safe?		Outstanding	☆
Are services effective?		Outstanding	☆
Are services caring?		Good	●
Are services responsive to people's needs?		Outstanding	☆
Are services well-led?		Outstanding	☆

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 Frome Medical Practice on the 10 and 11 June 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing safe, responsive, effective services and for being well led. They were also outstanding for providing services for all the population groups. They were good at providing caring services to patients.

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. For example, the practice had a hub team to reduce hospital admissions, which worked well to provide support to high risk patients and working in collaboration with the multi-disciplinary teams.
- 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 worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patient's needs.
- 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. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. 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:

- There were comprehensive systems in place to keep patients safe from harm and the team actively reviewed their safeguarding systems in order to do this. This included regular bi-weekly review of domestic violence notifications with all GPs.
- There was a comprehensive system in place to keep patients safe when taking high risk medicines. The system included when it was determined patients required outstanding diagnostic tests, patients had ease of access of the daily nurse led drop in clinic to enable them to have these checks completed quickly and enable them to continue with their medicine safely.
- The practice had a dedicated unplanned admissions hub team and had 3.5% of care plans completed working alongside multidisciplinary teams to aid the reduction in being urgently admitted to hospital. The practice had seen a slower rise in admissions in comparison to the previous year and had a lower percentage of admissions than other local practices in the area.
- The newly developed Health Connections Mendip service which was based in the practice and partly facilitated by the practice to build patients confidence to manage their own conditions and to develop and use services available to them for support. This had benefitted patients who have specific and not necessarily common conditions by new support groups being established and successfully represented by these patients.
- The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. Nurses led minor surgery clinics within the practice, 89% of patients seen in the last year had minor surgery completed by a trained nurse. They had been running since 2002 and received a practice nurse award in 2002 for making a difference.
- The practice had increased carer registration from 250 in January 2012 to 850 in May 2015. They linked with the local community hospital to increase awareness of the service provided by the practice and encouraged carers to register. The practice had a trained carers champion and often linked with Carers UK for advice and updates on information to provide to patients. All new carers were contacted by the carers champion and had a direct dial number to contact them in the future. New carers were provided with a carers information pack and there was an information stand for carers displayed in the practice.
- The practice had set up a weekly 'leg ulcer club' through The Lindsay Leg Club foundation in October 2014. The leg club was held in a non-medical setting enabling patients and others to receive a high standard of care for patients experiencing problems with their legs including leg ulcers. This occurred in a social and friendly setting that promoted understanding, peer support and informed choices. The practice funded the attendance of health care professionals during these clinics and the foundation funded the use of the facilities and refreshments. Since October 2014, 90 patients from the practice had been seen at the club for on-going treatment. The lead nurse for the leg club received a Mayor's Civic Award on 1 April 2015 for outstanding contribution to the community and was a reflection of how many leg club members were attending in a short period of time proving the club to be already successful.

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?

The practice is rated as outstanding for providing safe services.

This practice was improving consistently. All staff were open and transparent and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of safety. There were comprehensive systems in place to keep patients safe from harm and the team actively reviewed their safeguarding systems in order to do this. There was a comprehensive system in place to keep patients safe when taking high risk medicines, which took into account best practice. There were enough staff to keep patients safe and there was a comprehensive system to recruit new staff.

Outstanding



Are services effective?

The practice is rated as outstanding for providing effective services.

Our findings at this inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. They had a comprehensive system to record and take action when new patient safety alerts and new update guidelines were published. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients.

The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice. For example, a mental health nurse was employed to provide consistent care to patients with mild or moderate mental health problems. One stop clinics were provided for patients with more than one long term condition to reduce visits to the practice. Minor surgery was performed consistently by practice nurses and they had received an award for the success of providing this service through the nursing team rather than through the GPs. The practice had also implemented an unplanned admissions hub which working above suggested standards for their enhanced service arrangements, for example, they had a significantly higher percentage of patients using this service than the commissioner of the service had requested.

Outstanding



Summary of findings

The practice provided health promotion to patients through a new federation run health connections service which was based at Frome Medical Practice. This provided guidance, support and advice to patients and also implemented new local support services depending on patient need.

Are services caring?

The practice is rated as good for providing caring services.

National GP patient survey 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 for patients about the services available was easy to understand and accessible. We also saw staff treated patients with kindness and respect, and maintained confidentiality.

The practice had 850 registered carers at the time of our inspection. The increase in the number registered had been a significant achievement in comparison to January 2012 when there were 250 carers registered.

Good



Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. For example, implementing the successful leg ulcer club and Symphony project to improve self-care for patients with multiple conditions. They acted on suggestions for improvements and changed the way it delivered services in response to feedback from the Patient Participation Group (PPG). The involvement with the local community was integral to how services were planned and ensured services met patients' needs.

Patients told us they could be seen the same day to get an appointment but may have to wait up to three weeks to get an appointment with a named GP or a GP of choice. The practice recognised improvements were needed for patient satisfaction and had taken steps to address this. There was continuity of care for patients with complex needs and those needed to be seen by the same GP.

The practice had good facilities and was well equipped to treat patients and meet their needs. There was a proactive approach to understanding the needs of different groups of patients and delivered care in a way that met these needs and promoted equality. Information about how to complain was available and easy

Outstanding



Summary of findings

to understand, and the practice responded quickly when issues were raised. There was an active review of complaints and how they were managed and responded to and improvements were made as a result. Patients were involved in the review of complaints.

Are services well-led?

The practice is rated as outstanding 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 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. 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).

Outstanding



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

The practice is rated as outstanding for the care of older patients. The practice was rated as outstanding for effective, safe, well led and responsive services overall and this included this population group. The practice was rated as good for caring. The overall rating applies to everyone using the practice, including this population group.

Quality and outcome framework data showed that outcomes for patients were good for conditions commonly found in older patients. Actions were taken where there were areas for improvement. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in facilitating the timely diagnosis and support for patients with dementia. They were responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs including those residing in nursing and residential homes.

The practice had set up an unplanned admission hub team in July 2014, with 3.5% (997) care plans completed for patients at risk of being admitted to hospital, which was over and above their contract agreement. Each patient had a direct contact number to speak with a nurse practitioner if they needed support and advice. A number of multidisciplinary meetings were held weekly and monthly to ensure consistency of care and communication between services. Discharge summaries were often reviewed over and above the standard agreed and were often reviewed within one or two days of being received.

Outstanding



People with long term conditions

The practice is rated as outstanding for the care of patients 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. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Structured annual medication reviews were undertaken for patients with long term conditions, such as diabetes, chronic obstructive pulmonary disease (COPD), asthma, dementia and heart failure. We were shown data that 93 - 96% of these had been carried out in the

Outstanding



Summary of findings

last year. The practice provided one stop clinics for patients with more than one long term condition. Nurse practitioners with additional training in COPD, diabetes and asthma led these clinics and also carried out medication reviews. This enabled patients to receive their annual review and screening checks once or twice a year rather than up to six times a year.

The practice also ran a blood pressure titration clinic by the specially trained nursing staff. The trained practice nurses were trained to provide assessment, investigation, monitoring and titrate medications for patients with hypertension.

Families, children and young people

The practice is rated as outstanding for the care of families, children and young patients. The practice was rated as outstanding for effective, safe, well led and responsive overall and this included this population group. The practice was rated as good for caring. The overall rating applied to everyone using the practice, including this population group.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of accident and emergency (A&E) attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

The practice ran a specific young person's clinic every Wednesday from 3pm until 5pm, where young people from the local area could drop in and see a GP or nurse for support or treatment for sexual health, contraception, eating disorders, illegal drug use, counselling or general health queries.

Outstanding



Working age people (including those recently retired and students)

The practice is rated as outstanding for the care of working-age patients (including those recently retired and students). The practice was rated as outstanding for effective, safe, well led and responsive overall and this includes this population group. The practice was rated as good for caring. The overall rating applied to everyone using the practice, including this population group.

The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the

Outstanding



Summary of findings

services it offered to ensure these were accessible, flexible and offered continuity of care. The practice had a walk in service from 8:30am to 6:30pm Monday to Friday to enable patients to turn up for an appointment without booking an appointment prior to this. There were also pre-bookable appointments available throughout the week for early morning and early evening. There were also telephone appointments available. The practice provided a text reminder service to patients to remind them of their appointments. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

The practice is rated as outstanding for the care of patients whose circumstances may make them vulnerable. The practice was rated as outstanding for effective, safe, well led and responsive overall and this included this population group. The practice was rated as good for caring. The overall rating applied to everyone using the practice, including this population group.

The practice held a register of patients living in vulnerable circumstances including homeless people, people from the travelling community and those with a learning disability. The practice had 116 patients registered with a learning disability and 85% of them had received annual health checks in the last year. Where necessary, longer appointments were offered for patients with a learning disability.

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

Outstanding



People experiencing poor mental health (including people with dementia)

The practice is rated as outstanding for the care of patients experiencing poor mental health (including patients living with dementia). The practice was rated as outstanding for effective, safe, well led and responsive overall and this included this population group. The practice was rated as good for caring. The overall rating applied to everyone using the practice, including this population group.

Outstanding



Summary of findings

We found 52% of patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia. All administration and nursing staff had received dementia awareness training.

Patients with mental health needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined up care to these patients. Five years ago the practice employed a specialist mental health nurse to provide support to patients with mild or moderate depression. This had increased more GP appointments for other patients and the patients seeing the mental health nurse more consistent care. They also planned on starting joined-up working with the community mental health team to provide one stop appointments for patients for their physical and mental health checks. The practice hoped this would improve their annual review results for physical health checks.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. They had a system in place to follow up patients who had attended accident and emergency (A&E) when they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

From reviewing a number of information sources we found satisfaction with patient experience and the service provided was generally high. The sources we reviewed were comments made by 19 patients visiting the practice, those from four members of the Patient Participation Group and we received 74 completed Care Quality Commission comment cards from patients who visited the practice. We looked at the NHS Choices website, the national GP patient survey results and spoke with senior staff at two nursing and one residential care home who had a number of residents who were patients at the practice.

During our inspection we spoke with 23 patients who were very complimentary about the practice. Patients commented that they could use the walk in centre to see a GP the same day, but this could sometimes mean a long wait. Routine appointments normally had a long wait of up to three weeks sometimes to see a GP of the patient's choice. However, the majority of patients commented on how when they were seen treatment received was very good and GPs listened to patients and patients felt involved in their treatment.

We received 74 comment cards and a letter from a patient, which had been completed for us to view prior to the inspection. We found 88% of the 74 comment cards mentioned that patients were highly satisfied with all the staff at the practice providing exceptional care. We saw 36% of the cards mentioned about the length of time to wait to get an appointment with a preferred GP or the long wait patients had in the walk in centre before they were seen, sometimes up to three hours.

We reviewed NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been 14 patient comments made about the practice in the last year. Of these 12 of the 14 comments were positive about the service provided including the appointments system. The other two raised concerns about the appointments system. The practice had responded to the majority of these comments on the NHS Choices website and where necessary encouraged the patient to contact them to discuss their concerns further.

The practice showed us the results from the friends and family test during the period of January to May 2015. We saw the practice had an average of 80% patient satisfaction rate with the service provided and whether they would recommend the service to their friends and family.

We reviewed the national GP patient survey for the periods of January to March and July to September 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 116 patients had completed the surveys from the 295 sent. In summary and in comparison to the Somerset Clinical Commissioning Group (CCG) and national average patients were highly satisfied with having confidence and trust in their nurse. Patients were least satisfied with their overall experience of the practice, ability to see their preferred GP and being involved in decisions about their care by the GP. The survey results showed patients were not satisfied or were average in comparison with national and local results with the appointments system in all areas.

Outstanding practice

- There were comprehensive systems in place to keep patients safe from harm and the team actively reviewed their safeguarding systems in order to do this. This included regular bi-weekly review of domestic violence notifications with all GPs.
- There was a comprehensive system in place to keep patients safe when taking high risk medicines. The system included when it was determined patients required outstanding diagnostic tests, patients had ease of access of the daily nurse led drop in clinic to enable them to have these checks completed quickly and enable them to continue with their medicine safely.
- The practice had a dedicated unplanned admissions hub team and had 3.5% of care plans completed working alongside multidisciplinary teams to aid the

Summary of findings

reduction in being urgently admitted to hospital. The practice had seen a slower rise in admissions in comparison to the previous year and had a lower percentage of admissions than other local practices in the area.

- The newly developed Health Connections Mendip service which was based in the practice and partly facilitated by the practice to build patients confidence to manage their own conditions and to develop and use services available to them for support. This had benefitted patients who have specific and not necessarily common conditions by new support groups being established and successfully represented by these patients.
- The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. Nurses led minor surgery clinics within the practice, 89% of patients seen in the last year had minor surgery completed by a trained nurse. They had been running since 2002 and received a practice nurse award in 2002 for making a difference.
- The practice had increased carer registration from 250 in January 2012 to 850 in May 2015. They linked with the local community hospital to increase awareness of the service provided by the practice and encouraged carers to register. The practice had a trained carers champion and often linked with Carers UK for advice

and updates on information to provide to patients. All new carers were contacted by the carers champion and had a direct dial number to contact them in the future. New carers were provided with a carers information pack and there was an information stand for carers displayed in the practice.

- The practice had set up a weekly 'leg ulcer club' through The Lindsay Leg Club foundation in October 2014. The leg club is the first set up in Somerset with 16 clubs in total in England. The leg club was held in a non-medical setting enabling patients and others to receive a high standard of care for patients experiencing problems with their legs including leg ulcers. This occurred in a social and friendly setting that promoted understanding, peer support and informed choices. The practice funded the attendance of health care professionals during these clinics and the foundation funded the use of the facilities and refreshments. Since October 2014, 90 patients from the practice had been seen at the club for on-going treatment. The lead nurse for the leg club received a Mayor's Civic Award on 1 April 2015 for outstanding contribution to the community and was a reflection of how many leg club members were attending in a short period of time proving the club to be already successful.

Frome Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

We carried out our inspection over two days; on the first day we had a CQC Lead Inspector, GP specialist advisor, nurse practitioner specialist advisor and a second inspector. On the second day we had the CQC lead inspector and GP specialist advisor.

Background to Frome Medical Practice

We inspected the location of Frome Medical Practice, where all registered regulated activities were carried out. There was also a branch practice called Locks Hill, 95 Locks Hill, Frome, BA11 1NG, we did not inspect the branch practice site.

The practice serves approximately 29,000 patients and sees patients who live in Frome and the surrounding areas. The national general practice profile shows the practice has a higher than average to England population of patients aged between the ages of 40 to 49 years old. They are also below the national average for 20 to 39 years old. The practice is just above average for being one of the least deprived areas in this practice catchment area.

The practice is based in a purpose built medical centre where it has been providing services since December 2012. Previously the practice had three branch practices and now retains one of the branches called Locks Hill. Frome medical practice has 30 consulting rooms, seven nursing rooms and three treatment rooms. The building is split into a number of areas; two of these are for GP consultations, one for nurse clinics and the other is a walk-in centre for patients wishing to see a GP on the same day. The practice

also has an operating theatre where vasectomy operations are performed for patients and others in the local community. The operating theatre is also used by a consultant for private treatment for plastic and cosmetic procedures.

A range of additional services are provided from Frome medical practice and use their facilities including Somerset partnership community team such as district nurses and health visitors and mental health services including child and adolescent mental health services. East Mendip outpatients and an onsite pharmacy also use an area of the practice. A number of private health care businesses also use the facilities including chiropody, podiatry, physiotherapy, plastic and cosmetic surgery, acupuncture and an opticians. There is also an onsite café for all to use.

We were told the Locks Hill branch practice consists of two consulting rooms and two treatment rooms.

There were seven GP partners and 11 salaried GPs; nine male and nine female. There were also two long term locums employed. Each week all the GPs work the equivalent to approximately 18 full time GPs.

The practice was registered as a GP teaching and training practice. There are five GP trainers and the practice always had a minimum of four registrars each year. They provide training for medical students and qualified doctors training to be GPs.

The practice employs a mental health nurse to see patients through referral from their GP for mild to moderate mental health problems.

The practice employed ten nurse prescribers who could independently prescribe medicines for minor illnesses for patients. They also employed eight practice nurses and 15 health care assistants.

Detailed findings

The practice is open from 8am to 6:30pm Monday to Friday. Routine appointments were available with GPs between the following times; 8:30am to 10:30am, 11am to 1pm, 2pm to 4pm and 4:30pm to 6pm daily. Extended hours appointments are offered from Monday to Friday; Monday until 8pm, Tuesday, Wednesday and Thursday from 7am to 8pm and Friday from 7am. The walk in centre is open for on the day appointments from 8:30am to 5:30pm for appointments and from 5:30pm to 6:30pm for emergency appointments.

The practice referred its patients to NHS111 for out-of-hours services to deal with urgent needs when the practice was closed. From 1 July 2015 Somerset Doctors Urgent Care will also be an option for patients requiring primary care services out of hours.

The practice had a Personal Medical Services contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice was contracted for a number of enhanced services including extended hours access, facilitating timely diagnosis and support for patients with dementia, services for people with learning disabilities, minor surgery, patient participation, immunisations and remote care monitoring.

The practice had patients registered in eight nursing and residential care homes.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our inspection we had spoken with the Somerset Clinical Commissioning Group, NHS England local area team and Healthwatch Somerset. We carried out an announced visit on the 10 and 11 June 2015. During our visit we spoke with 40 staff including 11 GP's, the operations manager, two nurse practitioners, a mental health nurse, seven practice nurses, three health care assistants, one receptionist, one call centre administrator and 12 administration staff.

Collectively we heard from 97 patients during the inspection process. We spoke with 19 patients visiting the practice and four members from the patient participation group. We received 74 Care Quality Commission comment cards where patients shared their views and experiences of the service prior to our inspection.

Prior to the inspection we also spoke with three senior staff members from two nursing homes and a residential care home where there were residents who were registered at Frome Medical Practice, to gain their experience of the service provided.



Are services safe?

Our findings

Safe track record

The practice prioritised safety and 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. Staff were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, we spoke with three members of staff who said they had been involved in different significant events. They all told us they felt comfortable to report immediately to the management team and were then informed of the investigation process and outcome.

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

Learning and improvement from safety incidents

All staff were open and transparent and fully committed to reporting incidents and near misses. The level and quality of incident reporting showed the levels of harm and near misses, which ensured a robust picture of safety. The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw the practice had recorded 43 significant events since September 2014 until June 2015. We reviewed records of five significant events that had occurred during the last year and saw this system was followed appropriately. Significant events meetings (SEA) were held bi-monthly and included the significant event lead, quality assurance officer and any one member of staff from each team was encouraged to attend. This ensured all improvements and feedback was enabled to be fed back to the whole team.

We reviewed minutes from three significant event meetings from December 2014, February and April 2015. There was evidence that the practice had learned from significant events and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so. We heard blood had been taken from the wrong patient during an emergency situation which was happening at the practice on the same day. Staff were supported very well and

invited to a SEA meeting where the priority was what could be learnt to prevent any reoccurrence. It was decided that because staff checked the identity of the patient three times no major change could happen. However, staff were reminded of the policy of checking patients identity. Another example, when a patient collapsed in the waiting room and issues were raised about information being passed to the ambulance service. This was managed as a significant event. As learning, a checklist was now kept with a mobile phone which prompts staff to ask specific questions so they can speak with ambulance staff calmly and where possible the staff member making the call will be in the same room as the member of staff attending to the patient.

Staff accessed incident forms from the practice intranet and sent completed forms to their relevant manager or the health and safety lead. There was a system used to manage and monitor incidents. We heard of an incident where the waiting room chairs had become loose and heard it had been addressed in a timely manner. We heard any abnormal histology results from minor surgery were routinely managed as significant events. We tracked what had happened with an abnormal result and saw the patient had been promptly referred to and seen at the local acute hospital. The records showed this patient had been assessed as low risk prior to the removal of their skin lesion. Another example was when a confidentiality breach had occurred. An email had been sent to multiple recipients without being 'blind copied', which meant patients had access to other patients email addresses. This was reported to NHS England and the affected patients were informed and as a result the policy was changed.

National patient safety alerts were disseminated by the community pharmacist or lead GP to relevant practice staff and by notification on the staff intranet. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed with the community pharmacist and GP and if any protocols were changed this would be agreed and changes to patient treatment were changed, if necessary and the patient informed. This ensured all staff were aware of any relevant changes to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding



Are services safe?

The practice had systems to manage and review risks for vulnerable children, young people and adults. We read training records which showed that staff had received relevant role specific training on safeguarding for protecting children. We saw GPs had completed level three training, nursing staff level two and administration staff level one. Staff had also received role specific training on protecting vulnerable adults. GPs had completed a higher level course than other staff. Staff knew how to recognise signs of abuse in 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. We heard a number of examples from GPs of when they had shared information to other authorities when they were concerned about vulnerable adults including patients with a diagnosed learning disability, children and cases of domestic violence. Contact details were easily accessible within practice policies through the practice intranet, on the front page of the practice intranet and detailed in flow charts.

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

There were comprehensive systems to keep patients safe, which took into account best practice. The whole team was engaged in reviewing and improving safeguarding systems. 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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority. Domestic violence notification reports were reviewed regularly by the GP team every two weeks to highlight patients of concern. The health visitor was also alerted where necessary when children were involved. We heard examples of when there were a number of child absences for immunisations and the GP arranged a meeting with the child and mother to discuss concerns

around this. One of the GP partners and health visitors met every quarter to discuss child protection issues within the practice and health visitors were based in the practice and were routinely liaised with as and when issues arose.

GPs advised they would attend child protection case conferences if they were able to and understood the importance of them attending. If they did not attend they would send a report to inform the conference of their findings. We were told about when GPs had attended child protection case conferences and they provided examples of this, which ended in a positive outcome for the child. We were informed there was a risk tool for highlighting where there had been multiple non attendances for hospital appointments and these were followed up by the GP.

The practice had a chaperone policy which was available to staff through the practice intranet. The policy had last been reviewed in February 2015. We saw chaperoning was advertised to patients visiting the practice in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines storage in the clinical areas of the practice including medicine refrigerators and found they were stored securely and were only accessible to authorised staff. The theatre area refrigerator had an inaccessible plug to reduce the risk of being accidentally turned off. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature. These included daily checks by clinical staff and additional checks at the end of the day by staff responsible for securing the



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building. In addition, a member of the administration team remotely monitored the fridge temperatures throughout the building. Where there were temperature fluctuations that could not be explained an alarm alerted the duty manager for further investigation.

Processes were in place to check medicines were within their expiry date and suitable for use. However, these checks were not routinely recorded but there was a system for noting when medicines had been replaced. During our inspection the practice had produced a checklist to record when all checks were made. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. The practice had updated their prescription pad policy to ensure GPs did not routinely keep pads in their home visit bags and procedures were in place if they did.

There was a comprehensive system in place to keep patients safe when taking high risk medicines, which took into account best practice. There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. The prescribing team ensured this included that when the prescription was ready to be signed that they would print off relevant monitoring checks, such as the patient's latest blood test result. The system alerted staff when a patient required a blood test for example and the patient was able to use the drop in nursing service to have their test done whilst still in the practice. One of the GP partners also carried out a monthly review of these patients as an additional check.

The practice nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been recently updated. Health care assistants, depending on the training they had completed, administered flu vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that

nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber.

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.

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 and staff were able to describe how they would use these to comply with the practice's infection control policy. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a lead for infection control whose role was to support staff with any infection control queries and they linked in with the infection control lead at the Clinical Commissioning Group who provided them with support and advice. All staff received induction training about infection control specific to their role and received annual updates through the training academy. The lead for infection control completed quarterly audits. We saw the last audit completed in April 2015. There were some additional cleaning requirements needed and we saw this had been addressed with the specific department and completed in June 2015. Where necessary identified improvements were discussed at the weekly operations management meeting. If individual staff members needed to improve on any aspects then this was addressed with them individually.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap and hand towel dispensers were available in treatment rooms and toilets. Curtains were used in each consulting and treatment rooms. We saw a schedule in place to ensure they were cleaned every six months and on an ad-hoc basis, as and when required.

The practice had a facilities team managing the building and premises. Part of their requirement was to ensure checks were carried out for the management, testing and



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investigation of legionella (a bacterium which can contaminate water systems in buildings). We were told the cleaning team carried out weekly flush tests and a record was kept. The facilities team carried out any additional checks which covered the whole building.

We asked about infection control procedures for the community leg ulcer clinic. The nurse responsible for this explained the practice had adopted the infection control policies from The Lindsay Club foundation. The nurse told us the practice policies were not specific to this particular area. We were told the team used vinyl matting on the floor of the community setting which was wiped down between patients. All equipment, including trolleys and footstools were wiped down with clinical cleaning wipes and disposable liners used for buckets. Any clinical waste was returned to the practice for safe disposal.

The operating theatre areas were clean, tidy and uncluttered. Laminar flow systems (a safe method of transporting water) were in place and were used by the plastic surgeon only. Clinical cleaning wipes were used for equipment in between patients. The cleaners had a schedule in place to carry out cleaning within the theatre, which was included in the infection control policy including the necessity to wear overshoes whilst in the room at all times along with, gowns and gloves.

The practice used mainly single use equipment which did not require sterilisation. Instruments used for vasectomy were sent to the Central Sterile Services Department for sterilisation after use.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and some checks were carried out by building facilities team, which was monitored by the practice. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was June 2015. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and Electrocardiograms (ECG). Theatre equipment had been PAT tested earlier this month. The fridge used in theatre displayed stickers suggesting the fridge was due for recalibration in March 2016 and had been PAT tested earlier this month.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff which had last been reviewed in May 2015. We read four recruitment records from a selection of GPs, nurses and administration staff. We saw recruitment files contained evidence of appropriate recruitment checks which had been undertaken prior to employment. For example, proof of identification, employment history, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (DBS). (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). Staff were appropriately risk assessed to determine whether a DBS check was required depending on their role. We saw all chaperones had a DBS check.

There were arrangements in place for the planning and monitoring of staff and mix of staff needed to meet patients' needs. The practice had a specific team to organise and schedule GP and nurse practitioner sessions and manage annual and other leave requests. Team leaders managed other staffs leave including the nursing, front desk and call handling teams. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. 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.

Administration staff worked to a rota which organised the roles and responsibilities for the day. Staff said this worked well but was flexible if any changes were needed. Staff also said it made the job more interesting and varied.

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, staffing and equipment. Health and safety information was displayed for staff to see and there was a lead health and safety manager.

We saw a fire risk assessment had been completed in 2012 and had been reviewed in January 2015. The practice had recently received the reviewed risk assessment and would be arranging for any recommendations made to be



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completed. We saw completed fire logs which included weekly checks of the fire alarm, fire door exits and extinguishers. The emergency lighting was checked every six months by the facilities management team. The practice had fire drills regularly and the last one had occurred in January 2015. Most staff had received fire safety training in the last year and would have completed training the previous year. All new staff were shown fire procedures when they started.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage medical emergencies. Records showed that all staff had received training in basic life support. Non-clinical staff completed three yearly training and GPs and nursing staff every 15 months. The training was provided by an external company who showed staff procedures to follow using all the equipment and medicines available. Emergency equipment was available including access to oxygen, adult and child oximeters and an automated external defibrillator (AED) (used in cardiac emergencies). There were three sets of equipment used for medical emergencies, which was kept in easily accessible areas of the practice. We checked the AED pads and adult and child oxygen masks and saw they were within their expiry date.

The emergency medicines were kept securely within the prescription area in a grab box to enable staff to easily access them, when necessary. These included those for the

treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of severe pain. The reason for this was because there was an onsite pharmacy which was open during the same hours as the practice and could easily access this in an emergency. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. However, checks carried out were not recorded. The practice had set up a record to monitor this during our inspection and it was now in place. All the medicines we checked were in date and fit for use.

We saw significant event meeting minutes which showed staff had discussed a medical emergency concerning a patient and the practice had raised learning points to make further improvements to their medical emergency procedure. Staff we asked knew the location of the emergency equipment and medicines and records confirmed they were checked on a weekly basis.

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 had 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. For example, contact details of a heating company to contact if the heating system failed. The plan was last reviewed in May 2015.



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Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the lead GP how NICE and other relevant guidance was received into the practice. The lead GP recorded all new safety alerts and NICE guidance on a spread sheet. It was then recorded whether the new guidance or alert was relevant to the practice and if so it would be disseminated to relevant staff. It also recorded whether they carried out any audits in respect of this new guidance. For example, advice had been provided regarding a medicine which advised reducing the dose and duration of use. They conducted an audit with the community pharmacist to review their patients affected by this change. Other alerts where authorities advised not to use specific medicines, relevant stock was checked to ensure it could not be used. The same procedure occurred for NICE guidelines and these were reviewed for relevance to the practice and recorded to say what action was taken. NICE guidelines and patient safety alerts were discussed at bi-monthly significant event meetings and where necessary protocols were changed to reflect this guidance. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. For example, the triage nurse explained they would use guidelines such as the NICE traffic light flow chart for sepsis (infection).

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the nurse

practitioners and practice nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nurses we spoke with were open about asking for and providing colleagues with advice and support.

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

Management, monitoring and improving outcomes for people

Information about patient's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the operations manager and quality assurance officer to support the practice to carry out clinical audits.

The practice showed us their clinical audit record which showed eight audits had been completed in the last year. These included the fourth cycle of an audit to measure patient satisfaction with the vasectomy surgery provided by one of the GP partners. Previous audits had shown year on year increased levels of patient satisfaction with the service and a further audit performed for 2014 showed continuing high levels of satisfaction with the organisation of the service, and the care and attention from the GP surgeon. Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance. For example, a minor surgery audit was completed in January 2015 to review patients who had a minor operation in 2014. We saw 129 patients had received minor surgery and out of those patients 4.65% had a post operation infection and the standard was 5% and so the practice was achieving the standard rate. We also looked at another audit for GPs/nurses taking consent for contraceptive implants. The practice had completed 170 from March 2014 to February 2015 and out of these 163 had consent recorded. The target was 100% and so staff were reminded to record consent at all times.



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The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF) or Somerset Practice Quality Scheme (SPQS). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. SPQS is a locally based scheme aimed at improving services based on local patient's needs). For example, an annual medicines management meeting was held and GPs and the community pharmacist decided on which audits they would be completing following a review of areas they could improve upon. Monthly audits were completed to ensure procedures had been followed in respect of high risk medicines when repeat prescribing to ensure patients test results were not outstanding, where inconsistencies had been identified these were addressed with the prescribing GP and patient.

The practice had recognised that Somerset area was under-performing for antibiotic prescribing in comparison to national figures. We saw it was discussed in a GP team meeting and decided a data review on patients would be completed. The main improvement area for the team was to improve patient's knowledge of self-care rather than prescribe antibiotics. They planned to do some promotional work through using social media, local newspapers and the practice website.

The practice also used the information collected for the QOF, SPQS and performance against national screening programmes to monitor outcomes for patients. This practice was an outlier for QOF (or other national) clinical targets, they achieved 69.4% of the total QOF target in 2014, which was below the national average of 94.2%. This was accounted for by the practice participating in the Somerset Practice Quality Scheme (SPQS) and therefore was not providing all QOF data. The practice was still continuing to monitor long term conditions through their nurse clinics and alerts on the system. However, this would not be reflected under QOF data. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was worse than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was worse than the national average

- Performance for mental health related conditions was worse than the national average.
- The dementia diagnosis rate was comparable to the national average

The practice did not use QOF to monitor these areas and had specific members of staff reporting on areas for review where needed to focus on for QOF related monitoring. The practice also had exemptions this year to focus on increasing their flu vaccine intake overall rather than completing QOF outcomes such as diabetes. The practice also implemented the team hub to reduce hospital admissions as part of their SPQS. QOF alerts continued to be flagged during consultations to provide greater visibility for an opportunity to make a therapeutic intervention when a patient attended for another matter.

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

The practice's prescribing rates were similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked 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.

The practice had made use of the gold standards framework for end of life care. They had a palliative care register and 101 patients were registered on it. They had weekly multidisciplinary meetings with district nurses and the palliative care service to discuss the care and support needs of patients and their families. The practice had specific staff liaising with patients as well as the named GP including their urgent care practitioner, community practitioner and the unplanned planned admissions team.

Structured annual medicines reviews were undertaken for patients with long term conditions, such as diabetes, chronic obstructive pulmonary disease (COPD), asthma, dementia and heart failure. We were shown data that 93-96% of these had been carried out in the last year. The



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practice provided one stop clinics for patients with more than one long term condition. Nurse practitioners with additional training in COPD, diabetes and asthma led these clinics and also carried out medication reviews. This enabled patients to receive their annual review and screening checks once or twice a year rather than up to six times a year.

The practice also ran a blood pressure titration clinic by the specially trained nursing staff. The trained practice nurses were trained to provide assessment, investigation, monitoring and titrate medicines for patients with hypertension.

Patients with mental health needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined up care to these patients. Five years ago the practice employed a specialist mental health nurse to provide support to patients with mild or moderate depression. After a review of their consultations the GPs found that a significant part of their work was providing care to this patient group and so a specific mental health specialist could be beneficial to the service. This additional service increases GP availability as well as providing patients with more consistent care. The new initiative had been successful and freed up GP time equivalent to approximately three sessions per week. The mental health practitioner nurse saw each patient over six appointments with the initial appointment being 20 minutes and the other five 10 minutes each. They would review the patient's medicines, signpost to local support services and help patients on long term sickness to get back to work. A GP was always available to see the patient if they were suffering from a mental health crisis. They told us of a number of occasions when this had happened and the patient was seen in the walk-in service promptly. The practice also had two psychotherapists who used the practice facilities to see their own patients. GPs would use their expertise for support and advice when necessary.

The mental health community team was based in the practice. They had a plan in place to hold a joint well-being health clinic with the community team. This would involve a specific timed clinic each week when patients would see practice staff for their physical health check and care plan review and the mental health team could see the patient for their review at the same time. This would reduce visits to the practice for patients and a more coordinated approach and working together with community teams.

The safe use of innovative and pioneering approaches to care and how it was delivered were actively encouraged. The practice decided to train a practice nurse to complete minor surgery in 2002. Due to the success of the nurse led clinic, they won a practice nurse award in 2002 and another practice nurse was trained to complete minor surgery and health care assistants were trained to assist the nurses. All patients were initially seen by the GP for diagnosis and referral. All trained nurses attended a two day accredited course, six month mentorship with an accredited GP trainer and audits and surveys completed on procedures carried out. We saw that in the last year 89% of minor surgery procedures had been carried out by a trained nurse.

Staff described how they carried out comprehensive assessments prior to performing minor surgery and provided patients with information leaflets explaining what to expect and what risks were associated with the surgery. We saw histology tracking for minor surgery which showed what procedure had been done and listed any complications and details if histology was taken. This was done in a 'surgical procedure tracking book' and was completed by the two nurses who performed the procedures. The patients were advised to call in a couple of weeks if they had not received their test result in writing.

Effective staffing

There were 130 staff working in the practice which included GPs, nurse practitioners, triage nurses, practice nurses, a mental health nurse, community practitioners, a managerial team, call handlers, front desk staff, secretaries and other administrative staff. The continuing development of staff skills, competence and knowledge was recognised as integral to ensuring high-quality care. The practice had a well-developed system for monitoring staff training in mandatory courses, such as fire safety, manual handling, health and safety, infection control and equality and diversity through an online virtual academy. The system highlighted when training was overdue and any identified would be discussed at staff annual appraisals. Minimal staff were overdue for training and this was often for valid reasons such as they were a new starter. Generally where staff who were not new starters were overdue, they needed to complete the refresher course and this meant they had completed training from the previous year.

Staff were proactively supported to acquire new skills. The practice nurses had been trained to administer vaccines, blood pressure monitoring and had attended updates on



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cervical screening. Nursing staff had attended training courses about respiratory diseases and diabetes in order to maintain and increase their skills and knowledge in those areas. Further additional training had been provided to enable nurses to carry out family planning procedures, such as providing Intrauterine Device coils (IUD) and minor surgery training. Staff told us they had sufficient access to training and were able to request further training where relevant to their roles. Staff spoke with a sense of pride and told us Frome Medical Practice was a good place to work.

We noted a good skill mix amongst the GPs. They had specialism areas in obstetrics, gynaecology, child health, sexually transmitted infections and Human Immunodeficiency Virus (HIV), minor surgery and dermatology. We were provided with information to show GPs were up to date with their yearly continuing professional development requirements and had 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).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. New starters in the administration team generally started on the front desk and were able to progress their career development through other areas in the practice. The front desk had the biggest turnover of staff because of this. For example, there had been career progression into the health care assistant role, some health care assistants had then chosen to complete their nursing qualification and had returned to the practice afterwards. Front desk staff had also progressed through other administration roles such as recruitment or secretarial roles.

The practice had ten nurse prescribers who were qualified as independent prescribers and they received regular support in their role as well as updates in the specific clinical areas of expertise for which they prescribed. Nursing staff received annual appraisals and had monthly nursing meetings and additional monthly educational meetings.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Staff were aware of their responsibilities in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Out of hours reports and 111 reports were all seen and action was taken by a GP on the day they were received and home visits arranged, where necessary. Letters from outpatients or general hospital letters were allocated to the GP to review the following day unless there was anything urgent recognised on them. Pathology results were filed on the patient's record if normal and if abnormal allocated to the requesting GP who would then task any follow up options. The administrator would file normal results following guidance which clearly sets out what they should be checking against. In the administrators absence a GP would review all results.

Emergency hospital admission rates for the practice were the same as the national average at 13%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require a level of service provision above what is normally required under the core GP contract).

Staff, teams and services were committed to working collaboratively, patients with complex needs were supported to receive coordinated care and there were innovative and efficient ways to deliver more joined-up care to patients. The practice had set up an unplanned admissions hub in July 2014 in coordination with the East Mendip federation. The practice hub included nurse practitioners who specialised in community and urgent care, practice nurses and an administrator. As part of the commissioned service the practice had to complete care plans for 2% of their highest risk patients who were likely to be admitted to hospital. The practice had completed 3.5% of patients at high risk equating to 997 patients who had a care plan. All patients and where relevant, family members and carers had been invited in to the practice to discuss and involve them in decisions for their care plan. All care plans were reviewed on a six monthly basis or when needed. All patients who had a care plan were able to access the unplanned admissions hub directly using a



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direct contact number. Calls were taken by the nurse practitioners who were there to support and advise patients on any health related matters. The practice had seen a slower rise in admissions in comparison to the previous year and with other practices within the local area. For example, the practice had a 4.2% rise whereas other practices had their admissions rise between 9% and 15.4%.

Weekly multidisciplinary meetings were held with a GP who was involved with the community hospital assessment bed unit, district nurses and the unplanned admissions hub team. Monthly meetings were held with the other federation practices in the area, liaison nurses from the Royal United Hospital in Bath to coordinate care planning and communication, the independent living team in the area, social services, specialist heart nurse and the health connector's team (who provide peer support and social prescribing). There was also a weekly palliative care meeting with district nurses.

All discharge summaries were sent to the hub team to review within three days. The majority were often reviewed within one to two working days. We saw an audit reviewing discharges from February to March 2015, 80 patients had been discharged from hospital who had a care plan of those 86% (69 patients) had been reviewed within two working days. The standard for the enhanced service is 80% reviewed over three working days and the practice had reviewed 95%, so was working over and above its contract agreement.

Staff at the practice worked with external health care professionals. For example, one of the nurses worked in the out patients department based at the practice. They worked with consultants from the ear, nose and throat department (ENT), urology, paediatrics, ophthalmology, audiology, and diabetes. They set up the rooms and performed clinical cleaning on equipment such as nasal scopes. They also entered any data onto the acute hospitals trust and the practice computer systems.

The practice provided care and treatment to a number of patients who resided in four local nursing homes and four residential care homes. We spoke with a senior member of staff at three of these homes who provided us with positive feedback about the service provided. They said they had a good relationship with the practice and the practice involved families regularly in decision making, where necessary. If patient's living in the nursing home required urgent attention then this would be dealt with promptly, as

were any repeat prescription requests. They commented on how good and well organised coordinated care had been between the GP service and the community teams for arranging end of life care treatment and care. They also said GPs often visited the home when a patient was particularly unwell, on their way home, to check how they were, even if they had already visited in the day.

Nursing homes received a weekly ward round visit by a named GP in addition to any ad-hoc urgent visits in the week. Residential care homes received a two weekly visit by a named GP, where possible. Nurse practitioners and trainee GPs would also visit the nursing and residential care homes, where necessary.

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. For patients who were referred to hospital in an emergency there was a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

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

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 consent forms for minor surgery and histology results to be scanned into a patient electronic record.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The GPs and nursing staff we spoke with understood the key parts of the



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legislation and were able to describe how they implemented it. The practice had a comprehensive consent policy which provided clear guidance to staff on what they should consider when gaining consent from an adult or child. This included who should be involved in decision making and how consent should be recorded. The practice system had a template for GPs and others to consider when assessing a patient's capacity. This also ensured GPs were consistent in their recording and could easily identify if a patient's capacity had been reviewed. GPs spoken with provided examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. For example, a vulnerable adult had been subject to financial abuse and the GP was involved in making decisions in their best interests as it had been determined they lacked capacity.

GPs and nursing staff spoken with demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions). The practice provided a young people's drop in clinic for sexual health needs once a week. A GP told us that occasionally decisions needed to be made regarding the patient's competence to make an informed decision when they were not with their guardian. The practice system had a template for GPs and others to consider when assessing a young patient's competence. This ensured GPs were consistent in their recording and could easily identify if a young patient's competence had been reviewed.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for specific interventions. This had last been reviewed in June 2015. For example, for all minor surgical procedures, such as lesion removal or vasectomy, a patient's written consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition,

the practice obtained verbal consent for minor procedures, such as family planning and joint injections and a full record was provided on the system of what was discussed with the patient.

Members of the 'leg ulcer club' were asked consent to have photographs taken and for these to be shared on the leg club website.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and well-being. For example, by offering chlamydia screening to patients aged 18 to 25 years. The number of patients who had chlamydia screening from April 2014 to March 2015 were 240, which was an increase from 211 the previous year.

Smoking cessation from April 2015 had been procured by the commissioner from an external provider and so now the practice would refer patients requiring smoking cessation advice or support to this service. In the previous year April 2014 to March 2015 there had been 65 successful cases where patients had given up smoking, which was lower than the previous year when there were 115. The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed that 1393 patients in this age group took up the offer of the health check.

The practice's performance for the cervical screening programme was 79.5%, which was similar to the national average of 81%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening and we saw 35% had attended screening in the last two years for bowel cancer and 68% had attended breast cancer screening in the last three years.



Are services effective?

(for example, treatment is effective)

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 was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 64%, and at risk groups 40%. These were below national averages of 73% and 52% nationally. The practice was taking a number of actions to improve this including; starting flu vaccines earlier to reach more targeted groups, sending reminders to attend earlier, use of local media to encourage attendance and maximising opportunistic immunisations during other appointment visits.
- Childhood immunisation rates for the vaccinations given to under two year olds ranged from 94.4% to 98.6% and five year olds from 85.7% to 94.8%. The under two years old vaccinations were either above or similar to the CCG average. The over five year old vaccinations were mainly average except one where the practice was trying to find out further information from the Public health authority to check the accuracy of the data.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. Staff were committed and consistent in supporting patients to live healthier lives through a targeted and proactive approach to health promotion and prevention of ill health and every contact with patients was used to do so.

Health Connections Mendip was commissioned by Mendip federation to provide peer support and a social prescribing service to enable patients at Frome Medical Practice and others in the community to improve personal and community resilience. This may be on a one to one or group basis. The service was originally trialled in East Mendip and evidenced an increase of patients' confidence in managing their own condition. From April 2015 the service had expanded to the whole of the Mendip area and was funded by the primary care collaborative fund. The service provided support to adults who would like non-medical support with their health and wellbeing issues, such as managing long term conditions, increasing social wellbeing or changing health behaviours.

Frome Medical Practice supported the health connectors by providing for the volunteers to use the practice office facilities. The practice employed the volunteers on behalf

of the other Mendip practices. One of the GP partners had been influential in securing the funding for this project to enable it to succeed. Since May 2015 the health connectors had provided 26 one to one support sessions for Frome Medical practice's patients. GPs would signpost patients to the health connectors and since April 2015 there had been 110 signposts to the health connectors by GPs in the practice.

Patients have benefitted from this service so far through the setting up of local support groups for their specific need. For example, a patient with multiple sclerosis (MS) wanted to know who else had MS in the practice and local area. The health connectors identified 73 patients and they were all invited to a group meeting. The MS society attended the meeting along with 40 patients from the 73 identified. They decided they would like a weekly exercise group and this now takes place. Other groups that have been set up since April from patient feedback were; Parkinson's support group (35 out of 70 invited attended), breast cancer support group, stroke support group, Chronic Obstructive Pulmonary Disease support group and exercise for young women. Groups that had started in the trial period were still running due to their success and the health connectors still provided support for these groups including; macular degeneration (a condition that affects your vision) group, long term condition support group, leg ulcer club and mature movers. The practice had also enabled selected patients to have free use of the on-site gym to build their confidence in using community facilities.

The practice staff used every opportunity to offer health promotion and advice. For example, GPs would access information from the internet and print for patients. Triage nurses also signposted patients to other agencies such as advocacy, and counselling. The practice employed health connector volunteers who were able to refer patients to services including poverty help, advocacy services, pain management, mental health services, counselling, walking groups, befriending and transport services. GPs, nursing staff and reception staff could also refer patients to these services.

The local tissue viability nurse was employed by practice for a few hours per week and was invited to give advice and perform more complex assessment. The tissue viability nurse had also visited patients at home.

The practice ran a specific young people's clinic every Wednesday from 3pm till 5pm, where young people from



Are services effective?

(for example, treatment is effective)

the local area could drop in and see a GP or nurse for support or treatment for sexual health, contraception, eating disorders, illegal drug use, counselling or general health queries.

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice from the national GP patient survey from 2014 gaining views from 116 patients.

The evidence from national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect by the nurses.

However, patients were less satisfied with their interactions with the GPs. For example, data from the national patient survey showed the practice was rated 'among the worst' for patients who rated the practice as good or very good with 63.2% in comparison with the CCG average of 88.6% and national average 67.9%. The practice was also lower than average for its satisfaction scores on consultations with GPs and higher than average for nurses. For example:

- 79.3% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87.2%.
- 78% said the GP gave them enough time compared to the CCG average of 88.5% and national average of 85.3%.
- 87.9% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.8% and national average of 92.2%
- 85.8% said the last nurse they saw was good at listening to them compared to the CCG average of 81.5% and national average of 79.1%.
- 83.8% said the last nurse they saw gave them enough time compared to the CCG average of 82.5% and national average of 80.2%.
- 94.4% said they had confidence and trust in the last nurse they saw compared to the CCG average of 88% and national average of 85.5%

The GP's scores may have been lower than average because of staffing changes within the GP team. Feedback on the day from patients was mainly positive about the GPs.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 74 comment cards and a letter from a patient, which had been completed by patients for us to view prior to the inspection. We found 88% of the 74 comment cards mentioned that patients were highly satisfied with all the staff at the

practice providing exceptional care. Patients said they felt the staff were efficient, helpful and caring and treated them with dignity and respect. We also spoke with 23 patients on both days of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw staff were careful when discussing patients' treatments so confidential information was kept private. Call centre staff took patient telephone calls in an office away from the waiting areas and reception. The reception desk was based in the front entrance of the practice away from waiting room areas. There was a sign up for patients to ask them to wait behind a marker to enable confidentiality for patients. There was also a separate room that could be used to enable receptionists to speak with patients confidentially to help keep patient information private. Additionally, 78% of respondents to the national patient survey said they found the receptionists at the practice helpful compared to the CCG average of 89.1% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients who responded were generally positive in regard to questions about their involvement and explanations in planning and making decisions about their care and treatment and generally rated the practice well in these areas for nursing staff and lower than average for GPs. For example:

- 74.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85.6% and national average of 82%.
- 64.9% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78.4% and national average of 74.6%.

Are services caring?

- 82.1% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 79.2% and national average of 76.7%.
- 67.8% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 67.4% and national average of 66.2%.

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 mainly positive and aligned with these views. However, three patients felt they were not listened to and felt rushed by the GP.

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

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area for nurses and was lower than average for GPs. For example:

- 74.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86.1% and national average of 82.7%.
- 83.2% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.8% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information except for nursing staff where they were highly positive. For example, they highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the patient website also told patients how to access a number of support groups and organisations, such as for domestic violence and dementia.

The practice had 850 registered carers at the time of our inspection. The number registered had been a huge achievement in comparison to January 2012 when there were 250 carers registered. The practice had linked up with Frome Community Hospital to ensure patients were informed of the practice carers support when they were discharged they knew they would need or had a carer. The practice had a carer's champion who had been trained by Carers UK when they started their role. Part of their role was to be a contact for all new carers registering and any established carers. They had the ability to signpost them to local support groups and all new carers were sent a carers information pack. This included local carer's group's information, useful contact numbers, carer's brochure and an introduction letter from the practice. The practice's computer system alerted GPs if a patient was a carer. The practice also had a carers information stand displayed in the front entrance of the practice.

Staff told us if families had suffered bereavement, their usual GP contacted them. This call was followed by a patient consultation to provide them with advice and if necessary how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful. Nursing and residential care homes told us end of life care was excellent from the practice. They had good communication and coordination with the district nursing team. We were told GPs often increased their visits when a patient was nearing the end of their life, often this would be the GP visiting on their way home.



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 involvement of the local community was integral to how services were planned and ensured services meet patient's needs; social and physical. The practice had set up a weekly 'leg club' through The Lindsay Leg Club foundation in October 2014. The leg club was the first set up in Somerset with 16 clubs in total in England. This was a community based clinic for patients of Frome Medical Practice and others within the community. The leg club was held in a non-medical setting enabling patients and others to receive a high standard of care in a social and friendly setting that promoted understanding, offered peer support and informed choices. Members of the leg club received free tea and coffee, refreshments. It was not necessary to book an appointment. Treatments were provided for leg ulcers, varicose veins, skin tears and eczema.

The emphasis of the leg club was to empower members to participate in their care, in a social environment that eased loneliness by providing welcoming surroundings where old friends meet and new friendships formed. The clinic was run by a practice nurse and three health care assistants and supported on occasions by a bank practice nurse and on average 25-30 members attended each clinic. The practice funded the attendance of health care professionals during these clinics and the foundation funded the use of the facilities and refreshments. The practice had obtained funding from the community hospital which provided equipment and a Doppler machine (used in pregnancy to assist with monitoring the fetus). There was continued fundraising for the project and this had involved raffles, patient donations and a donation from a supermarket green token scheme. Since October 2014, 90 patients from the practice had been seen at the club for on-going treatment. The lead nurse for the leg club received a Mayor's Civic Award on 1 April 2015 for outstanding contribution to the community and was a reflection of how

many leg club members were attending in a short period of time. The Somerset Clinical Commissioning Group were monitoring the service to see if it could be rolled out elsewhere in Somerset.

The practice was part of a locally based project in the Mendip area of Somerset, called the Symphony project, which was aiming to provide enhanced support to patients with three or more diagnosed conditions. (The Symphony Project intends to redesign the way in which patients with multiple needs are cared for; integrating primary care, acute care, social care, community services, mental health services, housing, education, voluntary sector and the local authorities). When fully implemented each patient would have a named key worker who would develop a 'My life plan' with the patient. Each patient would then be placed into a risk based banding which identified who were self-managing their conditions, who required more support via a care co-ordinator and who would need regular reviews and end of life support. Practice staff would receive additional training to help support patients involved in the scheme. The practice had identified 30 patients so far who would fit this criteria and two patients have had involvement in developing a care plan for their needs.

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.

The practice had met with the Public Health team from the local authority and the CCG 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 population in the local area. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from patients. For example, the patient participation group was involved in decisions in regard to patient care including opening the walk-in centre and reducing patient non-attendance for appointments.

Tackling inequity and promoting equality

There was a proactive approach to understanding the needs of different groups of patients so that services were



Are services responsive to people's needs?

(for example, to feedback?)

was delivered in a way that met their needs and promoted equality. For example, longer appointment times were available for patients with complex health problems. The majority of the practice population were English speaking patients and the highest minority group registered was Polish. The practice had access to online and telephone translation services if they were needed. Patients were able to use Google translate on the practice website and touchscreens so booking in appointments could be translated into Polish.

The premises and services had been designed to meet the needs of patients with disabilities. The practice was fully accessible for wheelchair users. All consulting and treatment rooms were accessible for patients with mobility difficulties. There were accessible patient toilets and baby changing facilities. The waiting area had plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The reception desk was also lowered to enable patients using wheelchairs to easily access the reception desk. There was a hearing loop installed for patients who were hard of hearing. Reception staff told us they physically helped and supported patients who were blind or were a wheelchair user around the practice, for those patients who wanted help. The practice website included information on how to complain using British sign language to ensure it reached all its patients.

There were male and female GPs in the practice; therefore patients could choose to see a male or female GP.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in the last 12 months.

We saw that staff were careful to follow the practice's confidentiality policy and followed the practice information governance policies closely. One of the GP partners was a Caldicott champion (a senior person who was responsible for protecting patient information and enabling appropriate information sharing) and was also Information governance (IG) lead. Part of this role enabled them to set up an ethics group meeting which took place every quarter. A number of staff attended including the patient feedback champion, the IG lead, quality assurance officer, the operations manager and a member of the patient participation group. The group discussed patient confidentiality issues and improving access for patients

from minority groups. One of the areas that had been discussed was using text messages to inform patients of appointments or particular test results. The group had identified a potential risk of the content and the recipient being incorrect resulting in a potential breach of the patient's confidential information. As a result patient preferences were now recorded to include the patients preferred routes and details of communication. The group had discussed patient minority groups and found they could improve accessibility for Polish patients and had converted the practice complaints leaflet into Polish. They also wanted to see if they could increase the patient participation group attendance to include Polish representatives and had advertised attendance in a local shop, specialising in Polish food.

Access to the service

The practice is open from 8am to 6:30pm Monday to Friday. Routine appointments were available with GPs between the following times; 8:30am to 10:30am, 11am to 1pm, 2pm to 4pm and 4:30pm to 6pm daily. Extended hours appointments are offered from Monday to Friday; Monday until 8pm, Tuesday to Thursday from 7am to 8pm and Friday from 7am. There were 1000 GP appointments provided each week for patients.

To improve patient access the practice had opened an in-house walk in service for any patient to use if they required a same day appointment. The service was open from 8:30am to 5:30pm for routine appointments and from 5:30pm to 6:30pm for emergency appointments. Practice GPs and nursing staff worked in the walk in service on a daily basis using a rota system. All patients completed a form when they arrived at the walk in service to enable them to be prioritised. If they required diagnostic checks before seeing the GP such as an Electrocardiogram (ECG) and Blood pressure reading then these were completed by the healthcare assistant whilst they were waiting. We saw a report on the walk-in service which showed there had been a 14% rise in use of the service in comparison from April 2014 to April 2015. We also saw the average wait from January 2014 to April 2015 was approximately 40 minutes and in April 2015 97.8% of patients were seen within two hours.

Patients could also use the drop in blood clinic in the nursing station on a daily basis from 8:30am to 11:30am Monday to Friday and 2pm to 4:30pm Monday to Thursday. Patients could use this service if the GP requested for them



Are services responsive to people's needs?

(for example, to feedback?)

to have an ECG, blood test or blood pressure check. If convenient they could sit and wait after their GP appointment rather than having to book another appointment with the nurse at later time.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions, when required. This also included appointments with a named GP or nurse. Weekly visits were made to seven of the nursing and residential care homes and one residential care home received fortnightly visits from the GP. These visits took place on a specific day each week, by a named GP for those patients who needed to be seen. If these patients required an urgent home visit then this was also accommodated.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally the practice was rated average or lower than average in these areas. For example:

- 59.3% were satisfied with the practice's opening hours compared to the CCG average of 77.5% and national average of 75.7%.
- 46.7% described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 55% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 55.3% said they could get through easily to the surgery by phone compared to the CCG average of 76.8% and national average of 71.8%.
- 46.8% said they did not normally have to wait too long to be seen compared to the CCG average of 63.1% and national average of 57.8%.

Patients we spoke with were generally satisfied with the appointments system but said it was difficult to get an appointment with their preferred GP and often had to wait up to three weeks. They confirmed they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice and they have to wait sometime to be seen in the walk in centre. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients also 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, patients used the walk in centre if they needed an appointment urgently, although did become frustrated if they had to wait up to three hours to be seen. However, as stated above the majority of patients were seen within two hours of arrival.

The practice had recognised patient satisfaction was low from the patient survey results. They were keen to improve this and changed the practice in a number of ways to improve patient satisfaction, including the drop in clinics and walk in service. To further improve the service one of the GPs identified other similar practices with the same patient registration and similar set up as theirs in England. They found five other practices and compared themselves against the others in respect of the national GP patient survey. They found they were in the lower end of average for the areas covered. In July they planned to visit the practice who received most satisfaction from patients and the one who had the least satisfaction. This would enable them to share and receive ideas and improvements which would only benefit their practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled and oversaw all complaints in the practice. The complaints lead involved relevant management, depending on the team involved, and any other relevant staff to investigate complaints. The practice had a recently reviewed complaints policy which included how the patient could complain externally if they were not satisfied with the response from the practice.

We saw information was available to help patients understand the complaints system on the practice website and in the practice patient leaflet. However, this information did not provide up to date details on how to complain externally to the appropriate authorities or



Are services responsive to people's needs? (for example, to feedback?)

advocacy services that could be used. We noted this information was included in the practice complaints policy and the website had not been updated yet. 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.

There was an active review of complaints and how they were managed and responded to, and improvements made as a result. Patients were involved in the review of complaints. We saw 60 complaints had been received in the last six months and we read five complaints in full and found they had been satisfactorily handled and full responses provided to patients. All responses seen were acknowledged and investigated within the practice policy guidelines. The practice told us they may have a higher number of complaints due to them logging everything that patients were not happy about which were not necessarily formal complaints. This was because in the last year they now had a small dedicated team reviewing complaints and they wanted to ensure they had an appropriate system in place to manage complaints.

The practice reviewed complaints during weekly partners or operations meetings and also in quarterly significant events meetings. They also reported on complaints every quarter and annually to detect themes or trends. We read the last report for the period from January 2015 to March 2015 and saw there were themes of complaints particularly around diagnosis, care and treatment, appointments, staff attitude and communication. We saw lessons were learned from individual complaints, had been acted on and improvements made to the quality of care as a result. We saw that where necessary complaints were also discussed and recorded as significant events.

The practice had recently undertaken a small audit of patients who had recently complained and what their experience of the service was like. A total of 16 patient surveys were sent and six were received back completed. Two out of the six which had replied were not satisfied with the practice response. We were told these patients would be contacted by telephone to discuss their concerns further. The other four patients were satisfied with the action the practice had taken and response provided.

Are services well-led?

Outstanding



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

Our findings

Vision and strategy

The strategy and supporting objectives were stretching, challenging and innovative, while remaining achievable. 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 generally followed the short term business plan and vision for a year ahead. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. Staff were involved in implementing the practice vision and values and were asked for their views via email. We saw evidence to show how staff views had been implemented. The practice vision and values included enhancing the quality of life for individuals in the local community through the efficient use of all health care resources available. As a practice they wanted to ensure they were fair, accountable, professional, innovative and caring.

We spoke with 40 members of staff and all of those we asked knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

Governance arrangements

Governance and performance management arrangements were proactively reviewed and reflected best practice. The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 18 of these policies and procedures. Staff were provided with a policy reading list through the practice system and this alerted staff when they were overdue reviewing a new policy or an updated one. All staff were reviewed on this at their annual appraisal. Staff told us there were very effective search functions on the computer which helped when trying to locate a policy quickly. All 18 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 health and safety, one of the senior partners was the lead for safeguarding children and adults and others were Caldicott guardian, or

took a lead in mental capacity and information governance. Other GPs were the leads for clinical governance and audits and significant events. We spoke with 40 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 GP partners, operations manager and the management team took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Somerset Practice Quality Scheme (SPQS) and Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). We saw that performance data was regularly discussed at clinical meetings and action plans were produced to maintain or improve patient outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example the practice employed a community pharmacist to consistently review patient's medicines and those at risk. Areas of concern were identified at clinical governance meetings on a bi-monthly interval and further audits were implemented. Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. They had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example infection control audits had been completed and actions arising from the audit had been addressed. The practice monitored risks on a continuous basis to identify any areas that needed addressing.

The practice held 14 regular staff meetings where governance issues were discussed including partners meetings, GP team meetings, educational meetings for GPs, team meetings for the nursing and administration

Are services well-led?

Outstanding



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

teams and six monthly half day meetings with education available for all staff to attend. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The human resources manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as appraisals, training and supervision and recruitment of staff, which were in place to support staff. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Leaders had an inspiring shared purpose, to strive to deliver and motivate staff to succeed. The partners and management in the practice were visible in the practice and staff told us they were approachable and always took the time to listen to all members of staff. The administration manager sat with other staff within their open plan office to encourage staff to be open and work together as a team. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice. For example, all team managers were invited to the weekly operations meetings to ensure all areas of the practice were regularly reviewed and problems within departments highlighted quickly so they could be addressed promptly.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. We also noted that team away days were held every six months. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

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

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. They had 17 members of the PPG (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care) which included representatives from various

population groups; the working population, older patients, a member of Carers UK and patients in vulnerable circumstances. The PPG met with the operations manager, senior partners and/or other partners bi-monthly. We spoke with four members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. They felt they were the practices 'critical friend' and were involved in reviewing high level information about patient related services, such as key performance indicators for waiting times at the walk-in service.

They told us they had an open meeting with the practice and suggestions and ideas for improvement were always taken seriously. One of the aspects they felt their suggestions had helped to improve was reducing the level of do not attends (DNA) for patient appointments. In January 2013 the practice had 993 DNA's this had been significantly reduced in May 2015 to 504 DNAs over a period of a month. The PPG had suggested increasing patient knowledge of appointments, variance of ways of booking and cancelling, the practice also sent an article to the local paper to advertise the level of DNAs to further patient awareness. Systems had also been changed by the practice to increase appointment availability for patients, such as increasing the length of pre-bookable appointments to six weeks in advance.

The PPG had also influenced the implementation of the carers information stand and two computers for patients to access the practice website whilst they were in the practice. Within each waiting area there was a telephone pod to enable patients to ring the call centre staff to book another appointment. Patients had fed back that this was sometimes difficult to use because there was nowhere to sit whilst making the call. Each pod now has a chair for patients to use.

The PPG had assisted with patient health days which had become successful. The practice ran two health days in 2014 at the practice, one of the health days had an attendance of 143 patients and patients were able to receive general health checks such as BP and urine samples taken, from this 18 patients were sent for further investigation. Local support groups and health clubs attended to help publicise their work and how patients could join.

When the practice moved to the new site in December 2012, they had to close two branch sites in Frome because

Are services well-led?

Outstanding



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

of it. Some patients would have had to find other ways of transport to get them to the practice due to their locality. At the time the bus service did not stop at the entrance of the health park but on the main road near it. Some patients raised concerns how this had impacted on them due to mobility problems. The PPG helped to campaign for the bus services to change their route. The practice and PPG succeeded with this and the bus service now dropped patients off at the front of the practice.

There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. We saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. To further improve the service one of the GPs identified other similar practices with the same patient registration and similar set up as theirs in England. They found five other practices and compared themselves against the others in respect of the national GP patient survey. They found they were in the lower end of average for the areas covered. In July they planned to visit the practice who received most satisfaction from patients and the one who had the least satisfaction. This would enable them to share and receive ideas and improvements which would only benefit their practice.

The practice had also gathered feedback from staff through specific staff surveys through an anonymous survey company, staff away days were held every six months for all staff, regular staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they had provided feedback on another member of staff to one of the partners who dealt with the information sensitively and professionally with the staff member involved. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. For example, administration staff wanted to include urgent scanning on the rota. This was introduced. Another example included a change to home visit scheduling which was also implemented.

Management lead through learning and improvement

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

supportive of training and that they had staff away days where guest speakers and trainers attended. One member of staff had explained that she had worked at the practice initially as a work experience member of staff and had been supported within the practice to develop her role and then continue education resulting in re-employment back at the practice as a registered nurse.

The practice was registered as a GP teaching and training practice. There were five GP trainers. The practice provided training opportunities to both medical students during each year of university and for doctors seeking to become qualified GPs. There were currently four GP registrars in post. We spoke with one of them who told us they had been provided with longer appointment times with patients and this had been reduced as their training had progressed. They told us they always had a senior partner or GP trainer to discuss any issues or concerns with as they arose.

The practice was working with its federation to improve time taken to train and educate GP registrars. They planned to start delivering training for all trainee GPs at Frome Medical Practice, where GP trainers within the federation would be able to provide training in one place for all trainee GPs in the local area. This in turn would make best use GP trainer time for all practices.

The leadership team drove continuous improvement and staff were accountable for delivering change. There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. The practice had struggled to recruit salaried and partner GPs like most practices nationally. They decided on a new approach to tackling this issue by advertising for home working GPs. This was discussed with NHS England, Somerset Clinical Commissioning Group and the Local Medical Committee to gain their approval for this new approach. The practice now has three home working GPs employed who currently work a minimum of four hours per week each. Their tasks involve reviewing correspondence and tasking actions to relevant GPs and medication reviews. Future development of this role could be for the home working GPs to triage patient appointments.

One of the GP partners changed the referral system to help reduce time taken for GPs to complete these. All GPs no longer dictate letters instead the notes written on the patient record were used. GPs now had to ensure their consultation notes contained all the relevant information

Are services well-led?

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and this was then sent to the secretaries to send out along with the patient's medical history and a list of current medicines. This has generally improved GPs workload and the system proved to be more reliable.

One of the GPs partners had made a programme to enable all staff to see where particular members of staff were in the building. The information included whether they had a patient, what room they were in and their telephone number. This was particularly useful for reception and call centre staff when receiving queries from patients and they needed to find a GP.

The practice had three initiatives for engagement with the community which was a joint venture with the local county council in the federation area. This included using 'green' cars which patients could hire for car sharing initiatives and nurse practitioners used to carry out home visits daily between 9am and 1pm. The practice planned to have solar panels attached to the roof to reduce costs for practice, so this could be reused for improving patient care further. An automated external defibrillator was now situated outside the practice building for the public to use to assist people suffering from cardiac arrest outside of practice opening hours.