Stafford Medical Group

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Stafford Medical Group including Locking Castle Medical Centre and Stafford Place Surgery on Wednesday 4 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, caring, well-led and effective services. They required improvement for providing responsive services. We found all of the population groups were good.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed. Although the practice had not risk assessed the necessity of having paediatric pulse oximeters available.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients spoken with on the day of the inspection and through comment cards received said they were treated with compassion, dignity and respect. Although in comparison results from national GP survey were lower than average for GPs treating them with care and concern. However, the practice survey from 2013/2014 showed high satisfaction in these areas.
- Information about services and how to complain was available and easy to understand. However, this information was not included on the practice website.
- There was mixed views from patients about the appointment system; some patients did not like the telephone triage, whilst others did. We found patients had to wait long periods to be seen for their routine

Summary of findings

appointments and the practice could take action to improve this. Urgent appointments were available the same day either by telephone consultation or face to face if necessary.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on from patient reference group surveys. However, the results from national patient survey results were not always acted upon or addressed.

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

Importantly the provider must;

- Must review its protocol to ensure patients are not unnecessarily delayed when waiting for their appointments

The provider should improve on the following areas:

- Regularly review GP patient survey results and include this when making decisions about improving patients care.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

National data from the Quality and Outcomes Framework (QOF) showed patient outcomes were generally at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked well with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients spoken with and comment cards received said they were treated with compassion, dignity and respect. The practice survey showed high satisfaction in treating patients with respect, explanation, ability to listen, confidence in ability and consideration. National patient survey data showed that patients rated the practice lower than average or average to other practices for several aspects of care. Information for patients about the services available was easy to understand and accessible.

Are services responsive to people's needs?

Requires improvement

The practice is rated as requires improvement for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Feedback from patients reported that they were long waiting times when waiting for their routine appointment and there

Summary of findings

were areas where the practice could improve on this. There was a mixed view from patients when using the telephone appointment triage system. Although urgent appointments were always available the same day either by telephone consultation or face to face if necessary. The practice was equipped to treat patients and meet their needs. Information about how to complain was available within the practice and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

They had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which they acted on from patient reference group surveys. However, national patient survey results were not always included. There was an active patient reference group. Staff had received inductions, regular performance reviews and attended staff meetings.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients.

The Quality and Outcomes Framework showed outcomes for patients were average in comparison to national figures for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and was responsive to the needs of patients who were living with dementia or were receiving end of life care. They offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

The practice is rated as good 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. All these patients had regular reviews to check that their health and medication needs were being met. For those patients with the most complex needs, their GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients.

There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of A&E attendances. Immunisation rates were mainly average for all standard childhood immunisations. Patients told us 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.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students).

Summary of findings

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients whose circumstances may make them vulnerable.

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had carried out annual health checks for patients with a learning disability and 56% of these patients had received a follow-up. They offered longer appointments for patients with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients and prioritised completing housing forms for the homeless. 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.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with a dementia).

We saw 98.7% 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 a dementia.

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

Summary of findings

What people who use the service say

We found patient satisfaction from all sources was varied about patients experience at the practice with some high satisfaction and others with dissatisfaction in areas, such as the appointments system. We received 29 comment cards which had been completed by patients for us to view prior to the inspection. Five out of the 29 comment cards mentioned dissatisfaction with the appointment system. During our inspection we spoke with 12 patients who were complimentary about the practice but some were dissatisfied with the appointment system. The practice had recently changed the system to a triage system, so every patient received a phone call from a GP and it was then determined if they needed over the phone advice or whether they needed to attend the practice. Patients commented on how efficient the service was and helpful the staff were, when they contacted the practice and other patients commented on how the telephone triage system did not work for them.

During our inspection we met with the patient representative group which was formed in 2011. We met with five of the 12 members. They told us the practice was committed to improving patient care and included the group in the decision making process when changes were planned. The five patient representative's members spoke very highly of the service provided and the positive impact on the practice when it responded following suggestions made by the patient representative group.

Prior to our inspection we reviewed other information sources of patient views of the experienced with the service provided. This included NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been 12 patient comments made about the practice in the last year. Four out of 12 comments were positive about the service provided and the others raised concerns about the inconsistent care provided and the appointment system. The practice had an opportunity to respond to these comments on the website. However, they had not published any formal response.

We reviewed the national GP patient survey taken from patients 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 98 patients had completed the surveys from the 272 sent.

- 60% of patients surveyed said their overall experience of the practice was good in comparison to 83.9% North Somerset Clinical Commissioning Group (CCG) average and 85.2% national average.
- 85.9% of patients saying they trusted and had the confidence in the last GP they spoke with in comparison to 93.1% CCG average and 92.2% national average.
- 87.3% had confidence in the last nurse they saw in comparison to 87.3% CCG average and 85.5% national average.
- 44.9% of patients were able to see their preferred GP in comparison to 54.2% CCG average and 53.5% national average.
- 49.7% of patients said they were able to get through on the phone easily in comparison to 69.8% CCG average and 71.8% national average.
- Only 46.1% of patients surveyed said they would recommend the practice in comparison to 76.9% CCG average and 78% national average.

Areas for improvement

Action the service MUST take to improve

- Review protocol to ensure patients are not unnecessarily delayed when waiting for their appointments

Action the service SHOULD take to improve

- Regularly review GP patient survey results and include this when making decisions about improving patients care.

Stafford Medical Group

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team also included a GP, a second inspector and an expert by experience.

Background to Stafford Medical Group

We inspected the location of Stafford Medical Group, Locking Castle Medical Centre, Highlands Lane, Weston-Super-Mare, North Somerset, BS24 7DX and also its branch surgery; Stafford Place Surgery, 4 Stafford Place, Weston-Super-Mare, BS23 2QZ. All registered regulated activities were carried out within both of these premises.

The practice serves approximately 12,000 patients. The national general practice profile shows the practice has a higher than average to England population of patients aged between the ages of 0 to 14 years old and 40 and 44 years old. They are also below the national and local average for 55 years and older. The practice is in an average area for deprivation in this practice catchment area.

There were three GP partners and two salaried GPs and a long term locum; five male GPs and one female GP. Each week all the GPs work the equivalent to approximately six full time GPs.

There were seven female members of the nursing team which consisted of five practice nurses and two health care assistants and a phlebotomist. Each week all nursing staff work the equivalent to approximately four full time nursing staff.

The practice had a Personal Medical Services (a locally agreed contract negotiated between NHS England and the practice). Locking Castle Medical Centre had core opening hours from 8:00am to 6:30pm to enable patients to contact the practice. The branch practice Stafford Place Surgery was open reduced hours and patients could contact Locking Castle outside of these hours. The practice referred their patients to Brisdoc and NHS 111 service for out-of-hours services to deal with urgent needs when the practice was closed.

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?

Detailed findings

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 the inspection we spoke with the North Somerset Clinical Commissioning Group, NHS England local area team and the local area Healthwatch. We carried out an announced visit on the 4 February 2015. During our visit we spoke with 15 staff including three GP's, the practice manager, a nurse practitioner, two practice nurses, one health care assistant, three receptionists and four administration staff.

We spoke with 17 patients including five members from the patient representation group and reviewed 29 comment cards where patients shared their views and experiences of the service prior to our inspection.

Prior to the inspection we also spoke with one senior staff member from a residential home, where there were residents who were registered at Stafford Medical Group to gain their experience of the service provided.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, a member of the public allegedly photographed some confidential documents whilst at the reception desk. Staff reported this to the appropriate person and this incident was classed as a significant event. The practice changed their protocols and now all confidential documentation was kept away from the reception desk area.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We saw 10 significant events had occurred during the last year. Significant events were discussed with all GPs, the nurse practitioner, practice manager and reception supervisor at weekly meetings. There was evidence the practice had learned from these and 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.

Staff could access incident forms via the practice intranet or hard copy forms were available and completed forms were sent to the practice manager. They showed us the system used to manage and monitor incidents. We saw incidents were logged and evidence of action taken as a result. For example, a patient had been misdiagnosed for a condition. Another member of staff saw the patient and noticed the missed diagnosis. This was discussed with openly with the patient and they were referred to secondary care for further investigation. After this event an audit was carried out on all patients on the specific treatment relating to the missed diagnosis and further guidance was provided to all staff of the latest guidance in respect of this condition to prevent any further occurrences.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We read training records which showed that all staff had received relevant role specific training on safeguarding vulnerable adults and children. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in vulnerable adults and children. They were aware of their responsibilities of sharing information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible via the practice safeguarding policy which was available for all staff on the intranet. One of the nursing staff told us of an example of when they had used safeguarding procedures for a vulnerable patient and how support was obtained through social services.

The practice had appointed a dedicated GP to lead in safeguarding vulnerable adults and children. All GPs had been trained in level three child protection training and could demonstrate they had the necessary 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 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, a child who was on the child protection register.

We saw evidence of the practice advertising the use of a chaperone if a patient wanted one. There was a chaperone policy, which was visible on the waiting room noticeboard and 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). Nursing staff, including health care assistants and receptionists had received training through an external company on chaperoning.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. We saw medicines were kept at the required temperatures and staff knew what action to take in the event of a potential failure.

Good

Are services safe?

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

The nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

All prescriptions were reviewed and signed by a GP before they were given to the patient. If patients were required to see the GP or nurse before their next prescription then an alert was put on the system and note put on their prescription slip to remind them to book an appointment. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Cleanliness and infection control

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

The practice had a lead for infection control. All staff received training about infection control specific to their role. There had been an infection control audit completed in October 2014. The two areas for improvement had been addressed by the practice.

We saw personal protective equipment including disposable gloves, aprons, masks and couch coverings were available for staff to use. Hand washing sinks had hand soap and hand towel dispensers were available in treatment rooms.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. We were told and we saw equipment records which confirmed all equipment was tested and maintained regularly. We saw fire extinguishers and blood pressure monitors had been recently tested. The weighing scales were due to be calibrated as their last check was in August 2013. The practice manager informed us the usual company that completes these checks was unavailable and they had arranged for another company to carry out these checks and a number of weighing scales have been replaced. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date.

Staffing and recruitment

We read three recently recruited staffs recruitment files which contained evidence of appropriate recruitment checks that had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had completed a risk assessment in April 2013 to deem who required a DBS check. They had decided receptionists who chaperoned did not require a check as they were always with another member of staff. However, they told us they had ordered the applications for the outstanding DBS checks for all members of staff who carried out chaperoning within 24 hours after the inspection.

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

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

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 an identified health and safety representative.

Good

Are services safe?

We saw a fire risk assessment had been completed in January 2007. We saw completed fire logs and fire extinguishers had been regularly checked. There were two fire wardens who had last received training in July 2011. They were overdue for a refresher and this had been organised for the week after our inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all GPs and nursing staff had received training in basic life support. The practice manager informed us all frontline administration staff including receptionists had received basic life support training.

Emergency equipment was available at both sites including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Staff spoken with knew the location of this equipment. We saw there the equipment was checked on a weekly basis to ensure it was safe to use.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. We were told emergency medicines were checked within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Risks identified included power failure, 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.

Good

Are services effective?

(for example, treatment is effective)

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 found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate. For example, we heard from nursing staff that NICE guidance evidence based pathways were used for diabetes and chronic obstructive pulmonary disease. We were told information from the wound care formulary (2015) based on the best evidence available was used for wound care.

The practice was one of the most efficient prescribing practices in the North Somerset area saving approximately £100,000 annually for the NHS compared to comparable sized practices in the area. The practice was a higher than average antibiotic prescribing practice, which had been fed back by the medicines management team in North Somerset. The practice had taken action to address this and one of the GPs and the nurse practitioner had attended an Antimicrobial Prescribing study day and had fed back learning to the rest of the GP team.

The practice had an effective system for monitoring referrals to secondary care. In the local area they had the lowest number of errors when referring to secondary care. They achieved this through educating their administration staff to monitor all referrals to ensure they meet the local referral guidelines and contained all relevant information. The GP partners also reviewed any complex referrals made by salaried or locum GPs before submitting to secondary care. This reduced their rejection rate, which meant referrals were not delayed any more than necessary. They had often been praised by the level of rejections by the North Somerset Clinical Commissioning Group. The practice also worked hard to secure exceptional funding (funding for a typical or uncommon conditions which would need an additional funding agreement) for patients, which sometimes would take a significant amount of time to achieve. This included patients requiring a number of appointments with the GP, referrals to consultants and reviewing other options for patients. Exceptional funding often benefited patients psychologically and physically. We heard of three examples of where the practice had achieved funding for three individuals to improve their health outcomes.

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

The practice had the following enhanced services to improve outcomes for patients; facilitating a timely diagnosis and support for patients with dementia, patients with an increased alcohol intake providing some intervention to help reduce their intake, to provide support and an annual health check for patients with a learning disability and providing flu and child vaccinations/ immunisations.

We saw four clinical audits had been completed in the last year. The practice had completed two clinical audits led by North Somerset CCG. This included an audit cycle on Disease-Modifying Anti-rheumatic Drugs (medicines to slow down and treat symptoms of rheumatoid arthritis) reviewing all patients on these medicines ensuring patients were receiving the recommended testing whilst taking the medicines. The audit covered the periods 2012 to 2013 and 2013 to 2014. The results showed significant improvements in nearly all areas and actions were raised to further improve their results for the following year. Another audit was completed for child safeguarding as directed by North Somerset CCG. The audit reviewed child protection plans, discharge summaries for accident and emergency attendances and do not attends to appointments. The results showed an improvement on areas to action from 2013.

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). (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). For example, a diabetic control audit was completed to see where improvements could be

Good

Are services effective?

(for example, treatment is effective)

made to improving patient care and their QOF results. Audits were discussed with relevant staff members at team meetings to ensure all staff were aware of findings and how to improve practice

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. We saw the practice was slightly below the England and North Somerset Clinical Commissioning Group (CCG) average with 91.1% for completion of their QOF outcomes with an exception rate of 11.4%. The practice had an agreement with the CCG to opt out of QOF for the last three months of the year to enable them to support a number of vulnerable patients who needed to register at the practice following closure of a service. This meant the practice QOF score would be lower than average.

QOF results showed a higher than national average 97% of patients with diabetes had received an influenza immunisation and national average for 83% of patients receiving a foot examination. The practice was lower than national and local CCG average with 64.5% for patients who smoked who were offered support and advice to give up smoking. Also the percentage of patients with hypertension who had a blood pressure reading was below the national and local CCG average with 70.1%.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. Staff received training in mandatory courses, such as basic life support, fire safety, manual handling, health and safety, infection control and equality and diversity through an online virtual college. Some training they were in progress of completing and the practice manager was monitoring this. Staff received relevant role specific training including vaccinations and immunisation training, Electrocardiogram training, phlebotomy and cervical smear training. We noted a good skill mix among the GPs with two having additional diplomas in obstetrics and gynaecology medicine, and one with a diploma in children's health. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that 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, for example, the practice had supported two nurses in further education who now have the ability to independently prescribe medicines to patients. Another member of staff worked in administration and had completed training to enable them to be a phlebotomist and now have a part time phlebotomy role.

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. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. Administration staff reviewed the information and allocated to specific GPs. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

The practice held multidisciplinary team meetings weekly and three monthly to discuss the needs of complex patients, for example those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The practice provided care and treatment to a number of patients who resided in a local dementia nursing home. We spoke with a senior member of staff at the home who all 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

Good

Are services effective?

(for example, treatment is effective)

decision making, where necessary. If patient's in the nursing home required urgent attention then this would be dealt with promptly alongside any repeat prescription requests.

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. Electronic systems were also in place for making referrals, and the practice made referrals through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported this system was easy to use and assisted patients, when requested, to help book their appointments using the system.

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

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling them. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented them in their practice. When interviewed, staff gave 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 patient had been treated in hospital and there had been a 'do not attempt cardiopulmonary resuscitation (DNAR)' completed. A new DNAR had been completed following the GP hearing their views and appropriate authorities have been informed.

Health promotion and prevention

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. The practice had also identified the smoking status of 80.1% of patients over the age of 15 and 64.5% of these patients had been actively offered support and advice, both were below North Somerset CCG and England average. Patients wishing to give up smoking were offered an appointment with an advisor for smoking cessation.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. All 53 patients with a diagnosed learning disability were offered an annual physical health check. Since April 2014 to February 2015, 56% of the 53 patients had received an annual health check.

It was practice policy to offer a health check with the health care assistant 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.

The practice's performance for cervical smear uptake was 86.6%, which was higher than other practices in the national average. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Child immunisations performance from April 2013 to March 2014 showed three out of 16 were higher than average and two were lower for the CCG. The other 11 results were average with the North Somerset CCG area. We saw the uptake of flu vaccines was 73.9% from September 2013 to February 2014, which was above national average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national GP patient survey from 2014 gaining views from 98 patients and a survey of 244 patients undertaken by the practice's patient reference group in November, December 2013 and January 2014.

The evidence from all these sources showed patients were generally satisfied with how they were treated and that this was with compassion, dignity and respect. However, the GP patient survey showed they were lower than North Somerset Clinical Commissioning Group (CCG) average. For example, data from the national patient survey showed the practice was rated 'below average' with 60.1% in comparison with the CCG average of 83.9% for patients who rated the practice as good or very good. However, the patient reference group survey showed an 87% satisfaction rate with the overall practice. The practice was also below average for its satisfaction scores on consultations with the GPs and average with the nurses. For example:

- 74.3% said the GP was good at listening to them compared to the CCG average of 88.1% and national average of 87.2%.
- 75.5% said the GP gave them enough time compared to the CCG average of 86.8% and national average of 85.3%.
- 85.9% said they had confidence and trust in the last GP they saw compared to the CCG average of 93.1% and national average of 92.2%
- 76% said the last nurse they saw was good at listening to them compared to the CCG average of 80.6% and national average of 79.1%.
- 75.9% said the last nurse they saw gave them enough time compared to the CCG average of 81.5% and national average of 80.2%.
- 87.3% said they had confidence and trust in the last nurse they saw compared to the CCG average of 87.3% and national average of 85.5%

We were informed the practice did not regularly review its' results from the national GP survey to see if there were any areas that needed addressing. They informed us they would start doing this on a regular basis.

The practice survey results showed higher patient satisfaction in the above areas. For example, the practice survey asked about GPs and nurses ability to listen to patients, this showed a 95% satisfaction rate with patients stating it was either good, very good or excellent. The survey also asked patients whether respect was shown to them, this showed a 89% satisfaction rate and consideration was 91%. We saw evidence from individual GP and nurse practitioner surveys to show patients were satisfied with the care provided. The friends and family test showed patients were more likely to recommend the practice than not. For example, in May 2015, 27 patients said they were either highly likely or likely to recommend the practice to friends and family and three patients said they were unlikely too.

Patients completed 29 CQC comment cards to tell us what they thought about the practice. The majority of comments were positive about the service received with five patients mentioning their dissatisfaction with the appointments system. Patients said they felt staff were efficient, helpful and caring. Our expert by experience and another member of the inspection team spoke with 12 patients visiting the practice on the day of our inspection and we spoke with five members from the patient reference group. The majority of patients told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

Reception was shielded by glass partitions which helped keep patient information private and there was a separate patient room if patients wished to discuss confidential matters. Additionally, 69.1% said they found the receptionists at the practice helpful compared to the CCG average of 85.8% and national average of 86.9%. The practice survey said out of 243 patients, 97% of patients said warmth of greeting was either good, very good or excellent.

Good

Are services caring?

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and was rated lower than average in these areas. For example:

- 66.1% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 82.2% and national average of 82%.
- 61% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 75.3% and national average of 74.6%.
- 69.1% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 78.4% and national average of 76.7%.
- 58.2% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 66.8% and national average of 66.2%.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views. The practice survey showed that out of 243 patients showed 92% of patients said explanations provided by GPs and nursing staff were either good, very good or excellent. We also saw 94% of patients were confident in GPs and nursing staffs ability.

Staff told us that translation services were available for patients who did not have English as a first language. However, we saw there were no notices in the reception areas informing patents this service was available.

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 was rated lower than CCG average in this area for the GPs and average for the nurses. For example:

- 66.5% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 84.5% and national average of 82.7%.
- 76.6% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.3% and national average of 78%.

The practice survey showed out of 243 patients 92% felt staff concern for patients was either good, very good or excellent. We also saw 93% of patients could express their concerns and fears.

One patient provided an example of when they had been emotionally supported by the GP and was kind and considerate to their feelings.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted staff if a patient was a carer. The patient waiting area had a dedicated area for carers, providing information and support for these patients. The practice has a trained carer's champion who occasionally attends external carers meetings to support patients.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was followed by providing them advice on how to find local support services.

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice had been through a number of significant changes in the past year including a GP partner leaving and long term GP absence. This has impacted on the service and the number of locum GPs needed to be used to cover services. For the practice to maintain the level of service normally provided they had a long term locum to improve consistency for patients and had opted out of extended hours to reduce demand on the service provided. They had also recently recruited a salaried GP who told us they were being well supported by other colleagues.

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 responded to their high antibiotic prescribing rate and two GPs had attended a study day and fed back to the team to help reduce their prescribing rate.

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 the patient reference group (PPG). For example, the practice had implemented a partition screen in the reception area to improve patient confidentiality.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with a learning disability. The practice had also provided some patients with complex health needs a direct telephone number to enable them to contact the practice promptly. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of patients with disabilities. The main purpose built practice was fully accessible for wheelchair users and branch site was an older style building located at Stafford Place Surgery which was partly accessible. However, there was no onsite parking available. Consultations at the branch surgery could be organised on the ground floor for patients who had difficulty using the stairs. The consulting rooms in the main building were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

The practice manager told us they had six patients registered who were of "no fixed abode". There was a system for flagging vulnerability in individual patient records.

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

The practice provided equality and diversity training through e-learning. We saw the majority of staff had completed the equality and diversity training in the last 12 months.

Access to the service

The main practice was open from 8am to 6:30pm Monday to Friday. All patients could contact the main practice during these hours. The branch surgery was open reduced hours Monday and Friday from 8:30am to 1pm and 2pm to 6pm and Tuesday to Thursday 8:30am to 1pm.

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

Requires improvement

Are services responsive to people's needs?

(for example, to feedback?)

with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to one local care home as and when required, by a named GP.

The patient survey information we reviewed showed low patient satisfaction about access to appointments including waiting times to be seen for their appointments. For example:

- 69.6% were satisfied with the practice's opening hours compared to the CCG average of 76.8% and national average of 75.7%.
- 55.9% described their experience of making an appointment as good compared to the CCG average of 73.7% and national average of 73.8%.
- 39% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 57.9% and national average of 65.2%.
- 49.7% said they could get through easily to the surgery by phone compared to the CCG average of 69.8% and national average of 71.8%.
- 27.3% said they did not normally have to wait too long to be seen compared to the CCG average of 52.6% and national average of 57.8%.

Patients we spoke with were generally not satisfied with the appointments system and this was recognised by the practice. This included five comment cards and patients visiting the practice. However, some patients were happy with the system. The appointment system had been changed in the last few years to a duty telephone appointment system. This was where patients who requested an urgent appointment were called back by a duty GP and assessed on the telephone. Patients were provided with same day appointments either face to face appointments straight after a telephone call with the duty GP when needed or the GP could deal with their problem on the telephone. This particularly helped the working population. Patients were able to advise when they were unavailable for a call back and the GP would try to call back at the patients preferred time.

Patients were particularly dissatisfied with the time they had to wait to be seen for their appointment once in the practice. The national patient survey confirmed this and we heard from patients who told us they had to often wait up to 40 minutes to be seen by a GP or nurse. We checked the appointment system which confirmed sometimes this was case. There were often reasons for delays for patients to be seen, such as complex patients taking longer to be seen. However, staff confirmed two GPs did not begin their first consultations in the morning on time with delays of up to 40 minutes. This often meant patients would be seen late and there was a subsequent knock on effect for delays for patients throughout the day. GPs explained their delay in starting in the morning was due to working late into the evening due to lack of GP resources.

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 all complaints in the practice.

We saw that information was available to help patients understand the complaints system such as complaints information in the waiting area, a leaflet in reception and on the practice website. 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.

In the last 12 months there had been 13 complaints received. We saw the practice had taken action to address these and recognised learning points to improve the service. All complaints were discussed openly with all other GP partners when was received to ensure there was a transparent process.

The practice reviewed complaints annually to detect themes or trends. We read the report for the last review and a theme had been identified with a number of complaints which related to a GP which had recently left the practice.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and one year business plan. 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. The practice vision and values included providing the practice with health care at high quality and to continuously improving practices. We spoke with 15 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these visions.

Governance arrangements

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 read seven of these policies and procedures. We saw staff were asked to complete a form to confirm the date they had read the policy. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for safeguarding. We spoke with 15 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 and practice manager 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. This included using the 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). The QOF data for this practice showed it was performing in line with national standards.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. Evidence from other data from 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 a fire risk assessment had been completed and actions addressed. The practice monitored risks on a monthly basis to identify any areas that needed addressing. The practice held monthly staff meetings where governance issues were discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies on recruitment and induction 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

The partners 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. 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.

Monthly team meetings were held for all staff. 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 confident in doing so and felt supported if they did. 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 reference group (PRG), surveys and complaints received. They had an active PRG which

Are services well-led?

Good

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

included representatives from various population groups; older patients and working age population. The PRG had carried out annual surveys and met every quarter. They also had a virtual group to enable them to incorporate more views from patients who may not be able to get fully involved. They had a total of 44 member's altogether. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PRG. The results and actions agreed from these surveys are available on the practice website. We spoke with five members of the PRG and they were very positive about the role they played and told us they felt engaged with the practice. (A PRG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We were informed the practice did not regularly review its' results from the national GP survey to see if there were any areas that needed addressing. They informed us they would start doing this on a regular basis.

The practice had also gathered feedback from staff through 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. Additional training had been provided to staff, for example, two practice nurses had completed or were in the process of completing an additional qualification to enable them to prescribe medicines to patients. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, an audit of processes and further guidance was provided to staff after an incident had occurred.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect **Patients must be treated with respect at all times including not being left waiting for appointments for long periods unnecessarily.**