St James Medical Centre

Quality Report

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Date of inspection visit: 4 November 2014
Date of publication: 05/03/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

St James Medical Centre is a town centre practice providing primary care services to patients resident in Taunton. The practice has a patient population of approximately 13399.

We undertook a comprehensive announced inspection on 4 November 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor.

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

The overall rating for the service was good. Our key findings were as follows:

- Patients were able to get an appointment when they needed it.
- Staff were caring and treated patients with kindness and respect.
- Staff explained and involved patients in treatment decisions
- Patients were cared for in an environment which was clean and reflected good infection control practices.
- Patients were protected from the risks of unsafe medicine management procedures.
- The practice had the appropriate equipment, medicines and procedures to manage foreseeable patient emergencies.
- The practice met nationally recognised quality standards for improving patient care and maintaining quality.
- The practice had systems to identify, monitor and evaluate risks to patients.
- Patients were treated by suitably qualified staff.
- GPs and nursing staff followed national guidance in the care and treatment provided.

We saw several areas of outstanding practice including:

Summary of findings

- The practice also participated in schemes which promoted self-care for good health such as the diabetes education programme (DESMOND) and the use of telehealth systems.

However, there was an area of practice where the provider needs to make improvement.

The provider should:

- Ensure there are systematic processes in place to share learning from significant events and disseminate this amongst the all staff.
- Instigate a process to facilitate clinical audit cycles so that they are undertaken as a planned programme.

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 safe. The practice had a range of systems in place to ensure the safety of patients who used the practice. The environment was purpose built and well maintained. It was clean and tidy throughout with monitored cleaning schedules and infection control measures. Risks to patients were assessed and well managed. All staff in the practice ensured vulnerable patients were cared for appropriately and where there were concerns about a patient's vulnerability, the relevant authorities were alerted. There was evidence that the practice worked with other health and social care professionals to safeguard their patients and improve patients' health and treatment outcomes. Medicines were managed safely and prescribing medicines was monitored in line with current guidance. There were sufficient emergency medicines and equipment in place to ensure medical emergencies could be managed effectively.

Are services effective?

Good

The practice is rated as good for effective. The practice had systems and processes in place to ensure that standards of care were monitored and maintained. National Institute for Health and Care Excellence (NICE) best practice guidance was taken into account and the practice ensured all staff had access to information about improving outcomes for patients. For example, clinical audits had been completed and patients were supported to manage their own health. Patients were satisfied with the treatment they received and told us appropriate health care management plans were put in place to support their health and wellbeing. Staff told us they were very well supported by the provider and had access to information and training which helped them develop as individuals and as part of the practice team. There were good working relationships with other providers and innovative ways of making services available to vulnerable groups of patients. Health promotion and prevention was provided both in a targeted way and opportunistically by the practice.

Are services caring?

Good

The practice is rated as good for caring. We were told by patients they were treated with dignity and respect and staff provided privacy during all consultations. Reception staff maintained patient

Summary of findings

confidentiality when registering or booking in patients. Staff gave patients the information they required about their treatment to ensure they were able to make informed choices. Services were provided by caring and involved staff.

Are services responsive to people's needs?

Good

The practice is rated as good for responsive. The practice reviewed the needs of their local population and engaged with the NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) to secure service improvements where these were identified. Patients reported good access to the practice and a named GP with continuity of care. Urgent appointments were available the same day. The GPs and nurses worked with patients to promote self-care and independence in a responsive way. The practice had good facilities and was well equipped to treat patients and meet their needs. There was an accessible complaints system with evidence demonstrating that the practice responded quickly to issues raised. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for well-led. The practice had a clear vision and strategy to deliver this. The leadership, management and governance of the practice assured the delivery of high quality patient centred care, supported learning and innovation within and outside of the practice and promoted an open and fair culture. Governance arrangements covered all aspects of the practice and minimised risks to patients. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients and this had been acted upon. The practice had an active patient participation group (PPG). Patients spoke positively about their experiences within the practice and told us they felt the practice was well led, friendly and effective.

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 statement of purpose for the practice sets out the key philosophies for the care and treatment of all patients, whichever population group to which they belonged. The practice worked hard to achieve quality patient care for older patients and maximised patient choice through being able to see and /or speak with their usual GP or any other GP in the practice. The practice provided a wide range of expertise within the nurses and GPs who routinely updated their specialist skills. The practice provided a named accountable GP for all patients aged 75 and over. We found the practice was committed to keeping older patients as well as possible and worked collaboratively with other agencies to avoid unplanned admission.For patients requiring end of life care and support, was held every three months with the lead GP and the other GPs in session . The practice maintained a palliative care register of patients which was updated as appropriate and the care needs of patients were regularly reviewed. The practice also supported older patients living in residential or nursing homes locally.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions. The practice provided specialist nurse support for conditions such as asthma, diabetes and heart disease. They worked well as a team with the lead nurse ensured they undertook all necessary training to keep their knowledge up-to-date. These combined skills and knowledge in different areas complemented one another and provided a comprehensive service for patients. Patients' conditions were monitored and reviewed with planned appointments sent directly to them.We found patients were assessed and signposted to the most appropriate provision. For example, all newly diagnosed diabetic patients were invited to attend a locally arranged group course in managing their diabetes. The lead nurse had specialist knowledge and awareness of diabetes, and had developed and promoted insulin initiation, without the need for referral to the hospital. All of the practices diabetic patients attended a yearly review.The practice promoted self-care and offered patients with long term conditions an assessment and education for monitoring their condition. The practice was able to offer home visits for patients who could not routinely visit the surgery. All medically vulnerable patients were subject to risk assessment and if needed had a care plan which could include emergency medicines such as antibiotics or steroid therapy. The

care plan was available to the Out of Hours service. Tele-health was offered to patients with long-term conditions such as hypertension and chronic obstructive pulmonary disease. The practice also used a local risk assessment tool to identify the most vulnerable patients with complex needs.

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people and staff had specialist childcare knowledge. Systems were in place for identifying and following-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 high for all standard childhood immunisations. Patients told us, and we saw evidence that, children and young patients were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We were provided with good examples of joint working with midwives, health visitors and school nurses. The practice liaised with a range of other agencies regarding patients for example, the sexual health clinic. Young adults were able to access confidential appointments with a GP who ensured the person was competent to make decisions for them self using the Gillick competence guidance.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the population group of the working-age patients (including those recently retired and students). GP and nurse appointments were arranged to accommodate work commitments when required by patients. The practice also provided telephone consultations and an electronic prescription service to the patient's nominated pharmacy. NHS health checks were offered to all patients aged 40-74. We found the practice participated in health screening programmes such as the national cervical cancer screening programme.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the population group of patients whose circumstances may make them vulnerable. The practice had a system of identifying those patients in vulnerable circumstances who may have difficulty accessing services such as those with learning disabilities or those patients whose first language was not English. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to recognise signs of abuse in

Summary of findings

vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in and out of hours. The practice operated shared care schemes with local drug and alcohol rehabilitation services. The practice registered patients of no fixed abode or were transient in the area to enable them to access health services.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the population group of patients experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. The practice had sign-posted patients experiencing poor mental health to various support groups and third sector organisations. The practice had a system in place to follow up on patients who had attended accident and emergency where there may have been mental health needs. Staff had received training about how to care for patients with mental health needs and dementia. Patients at the practice had access to psychological therapies and self-help groups.

Summary of findings

What people who use the service say

Patients described the practice as excellent and helpful and told us they would recommend the practice to other patients.

The practice completed an annual patient satisfaction survey for 2013. This showed the practice exceeded the national average result from the national patient satisfaction survey as 97.61% of patients rated the practice as providing a good patient experience. The practice had also completed a Friends and Family Survey which received a return of 97.3% of positive patient responses with 78.6% of patients extremely likely to recommend the practice. All of the patients we spoke with said they would recommend the practice.

The survey results were corroborated by the comments made by the four patients we spoke with during our visit. We also had thirteen patients who had completed our comment cards and these showed a high level of satisfaction with all areas of the practice, including very positive comments made about staff being highly skilled, respectful and considerate, with GPs listening to patients and providing clear explanations of the problem. Patients told us they saw their own GP and were informed when their GP was holding surgery at the practice as this information was on the website. Being able to see the same GP provided patients with continuity of care and patients were confident the GPs had a good awareness of their needs including what they understood about their health.

The practice had a Patient Participation Group (PPG) that consisted of six members who attended the practice for face to face meetings and a wider Patient Reference Group which was an email community used to gain opinions, ideas and to participate in surveys. The 165 patients currently comprising this group represented the demographic of the practice. The practice arranged regular meetings with PPG members to discuss any improvements that could be made to the practice. We spoke with the chairperson of the PPG. We were told the practice had listened to the group and took their views into account when making decisions about the practice. For example, the practice had supported the PPG to plan a diabetes awareness evening for practice patients in November 2014.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve

- Ensure there are systematic processes in place to share learning from significant events and disseminate this amongst all the staff.
- Instigate a process to facilitate clinical audit cycles so that they are undertaken as a planned programme.

Outstanding practice

The practice also participated in schemes which promoted self-care for good health such as the diabetes education programme (DESMOND) and the use of telehealth systems.

St James Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to St James Medical Centre

The practice is located at the Coal Orchard in Taunton town centre. The patient population of 13399 was predominantly white British. The practice has an above average number of patients aged 25 - 34 years and generally below the national average number of patients aged over 55 years. The catchment area includes the town centre population and the practice has a significant number of patients with substance and alcohol misuse problems. The catchment area also includes two areas of deprivation and patient turnover is quite high amongst the younger transient population. Prevalence rates for chronic diseases such as heart disease, diabetes, hypertension and COPD are slightly below the national averages, explained by the higher than average number of patients in the younger age group.

The practice also supports patients in residential and nursing care homes and acts as the medical officer to a residential school and the county cricket club. The patient reference group is made up of a representative mix from the patient group.

St James Medical Practice is provided from two locations:

St James Medical Practice

Coal Orchard,

Taunton,

Somerset

TA1 1JP

And a branch surgery at:

Orchard Medical Centre,

Norton Mills,

Morse Road,

Norton Fitzwarren,

Taunton,

Somerset

TA2 6DG

This was not visited as part of this inspection.

The practice is contractual responsible from 8am to 6.30pm Monday to Friday with phone calls taken from 8am – 6.30pm and buildings open at St James Medical Centre open Monday to Friday 8.30am - 6.30pm and the branch is open from Monday to Friday 8.30am – 6.00pm and closed 1pm to 2pm on Friday. Extended hours are for pre booked appointments only at St James Medical Centre on Saturday 8.30am – 11.30am. There are daily urgent care appointments for patients with an illness requiring same day medical care.

The practice operates as a partnership between eight GPs and one salaried GP who work a total of 56 sessions across the week between the two locations. The practice also employs five practice nurses and a nurse practitioner. The practice does not offer Out-of-Hours care, but provides information to patients about Out-of-Hours and emergency appointments which are provided by another agency. This information is also available in the practice brochure and on their website.

Detailed findings

The practice has a General Medical Services (GMS) contract and also provides a range of enhanced services.

Why we carried out this inspection

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

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.

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

How we carried out this inspection

Before visiting, we reviewed a range of information we had received from the out-of-hours service and asked other organisations to share their information about the service.

We carried out an announced visit on 4 November 2014 between 8.00am - 5.00pm.

During our visit we spoke with a range of staff, including GPs, nurses, practice manager and administrative staff.

We also spoke with patients who used the service. We observed how patients were being cared for and reviewed the patient information database to see how information was used and stored by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older patients (over 75s)
- Patients with long term conditions
- Mothers, children and young patients
- Working age population and those recently retired
- Patients in vulnerable circumstances who may have poor access to primary care
- Patients experiencing poor mental health.

The information from the practice showed the patient demographic profile for the population groups was:

- Vulnerable older patients (over 75s) 8.5%
- Patients with long term conditions 18.9%
- Children and young patients 27% (under 18 years)
- Working age population and those recently retired 61%
- Patients in vulnerable circumstances who may have poor access to primary care 2%
- Patients experiencing poor mental health 1.4%

% of patients from BME populations 10.41 **%**

Good

Are services safe?

Our findings

Safe Track Record

The practice used a range of information to identify risks and improve quality in relation to patient safety. For example, we were shown the Somerset Risk Tool which identified those patients who were at greatest risk of unplanned hospital admission and prompted intervention. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses. We reviewed safety records and incident reports and minutes of meetings which showed the practice had managed these consistently over time.

The practice used an electronic patient record system. Any significant medical concerns or additional support needs were added as alerts to patients' records. These appeared when a record was opened and alerted the GP or nurse to anything significant relating to that patient and their care. For example, if a patient had communication difficulties or had missed an appointment. Staff also understood that patients may be supported by a carer or a relative to act as an advocate for them, and this information was recorded on the patient record. Routine recall appointment alerts were entered into the system to ensure patient care and treatment was monitored and so that patients were reminded to have their medical conditions reviewed. The GPs and nurses we spoke with told us about routine condition and medicines reviews. The GP and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Somerset Clinical Commissioning Group (CCG), Somerset Local Medical Committee (LMC) completing online learning courses and reading journal articles.

Learning and improvement from safety incidents

The practice had a written procedure in place for reporting, recording and monitoring significant events, incidents and accidents. Staff including receptionists, administrators and nursing staff were aware of the system for raising issues and were confident to do so. Records were kept of significant events and those that had occurred since February 2014 and these were made available to us. Incidents were recorded and if reportable, sent to the practice manager who explained how they were managed and monitored. We tracked 10 such incidents and saw they were discussed within the team and actions to prevent recurrence were identified. We asked the GPs how they dealt with incidents that impacted on patient care. We were told by the GPs at the practice they were aware of their responsibility to complete a significant event form for investigation and action. We were told significant events were discussed with peers as they arose as urgent action may be required. A slot for discussion of significant events was on the monthly practice meeting agenda. We did not see any evidence that appropriate learning or any findings were disseminated to relevant staff. Meeting minutes did not provide a complete record of the discussions from which information could be shared. Before the end of the inspection the practice had put in place a system to record the outcomes of incidents and any corrective actions needed following any incidents. This system gave a mechanism to share any learning or action with all staff to avoid repeated problems. There was an annual overview of significant events collated by the practice manager. This enabled the practice to review any themes and change processes when needed.

National patient safety alerts were disseminated by the practice manager to the senior partner and relevant practice staff. The practice manager told us alerts were discussed at the weekly practice business meeting to ensure if any action needed to be taken everyone was clear about their area of responsibility. Staff also confirmed information was shared however there was no system to ensure any remedial action agreed had been implemented by the team. The GPs told us how they dealt with drug safety alerts and how this impacted on their prescribing for patients. The practice had a summary of prescribing audits, which enabled the information and action indicated by drug safety alerts was implemented by the practice. The practice manager also received Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and took appropriate action as needed.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable patients. The GPs confirmed they applied the same safeguarding principles to patients who lived in care homes settings as they were perceived to have a greater degree of vulnerability. The electronic records system had an alert system so staff were made aware there were other important issues to consider when these patients attended appointments. For example, one GP told us patients on his

list with a learning disability had an alert which would indicate to the receptionist that a longer appointment may be needed. We were also shown the practice had a system in place to monitor patient attendances at accident and emergency centres and their use of out of hours and urgent care centres, all of which they felt indicated higher risk or vulnerability.

The practice had a dedicated GP appointed as lead for safeguarding vulnerable adults and children. The GP had been trained to level three training to enable them to fulfil this role. The practice had ensured all staff had attended safeguarding training commensurate with their role. The lead safeguarding GP was aware of vulnerable children and adults and demonstrated good liaison with partner agencies such as the police and social services. GPs met regularly with health visitors to enable regular discussion and information sharing about 'looked after', 'at risk' children and any vulnerable families. The practice manager confirmed these arrangements worked well and the health visitors could access the staff at the health centre easily to share information. The practice had made approximately 12 referrals of children where concerns had been identified over the past 12 months. The GPs confirmed they had been invited to attend case conferences but could not always attend however; they completed any documentation for the meetings and were provided with minutes and actions. They confirmed that they were sometimes required to attended serious case reviews for patients registered with the practice.

Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact the relevant agencies in and out of hours. We observed contact details were easily accessible around the practice. The GPs and nurses were aware of the Gillick competence requirements and ensured children were accompanied by an adult if they needed to see a GP or nurse until such time as they could demonstrate understanding to consent to their own treatment. A chaperone policy was in place and visible on the waiting room noticeboard. Chaperone training had been undertaken by all nursing staff, including health care assistants.

Patients' individual records were written and managed in a way to help ensure safety. Records were kept on an electronic system which allowed for collation of all communications about the patient including scanned copies of communications from hospitals. This system allowed other healthcare professionals access to add clinical records and test results which improved communication between the practice and attached staff. This was a new system to the practice; however the practice manager was alerted by practice staff of any issues with the system and could access support.

Medicines Management

We found medicines were prescribed and given to patients appropriately. The senior partner was the Prescribing and Medicines Management lead for the Taunton Federation of GP practices and had conducted audits of medicine prescribing within the practice.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines which required refrigeration were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure of the refrigerator was described. 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 disposal regulations. We observed that medicines which were subject to additional storage regulations had been recorded and stored correctly.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance. The health care assistant also administered vaccines under patient specific directions which had been reviewed and approved in line with national guidance and legal requirements. 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. One nurse was a qualified nurse practitioner and independent prescriber. We were told they received regular supervision and support in their role, and had opportunities to update skills in the specific clinical areas of expertise for which they prescribed.

There was an electronic prescription service available at the practice which allowed prescriptions to be sent to a

patient's nominated pharmacy. This system was not used for blank prescription forms which were stored securely, however there was no record of serial numbers which would allow the forms to be tracked once removed from the secure storage. There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. This helped to ensure that patients' repeat prescriptions were still appropriate and necessary. There was a system in place for the management of high risk medicines, for example prescribing controlled drugs. GPs and nurses were responsible for monitoring the effectiveness of diagnostic testing. An alert was placed on the computer system to ensure relevant tests had taken place and it was safe for the patient to continue taking the prescribed medicine.

The practice set a target of getting medicines to patients within 72 hours. This included 48 hours to write the prescription and 24 hours for the pharmacy to receive and process. These were overseen by individual GPs who would be aware of any discrepancies and changes to medicines for their patients. We were told when patients were discharged from hospital the GPs read the discharge summary and made adjustments to medicine records.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. We saw there were cleaning schedules in place and cleaning records were kept. Hand hygiene technique signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. 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 professional for infection control who provided advice on the practice infection control policy and carried out staff training. All staff received induction training about infection control specific to their role and thereafter annual updates. We saw evidence the lead person had carried out audits for each of the last three years and that any improvements identified for action were completed on time. An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy.

The practice had a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). We saw records that confirmed the practice was carrying out regular checks in line with this policy in order to reduce the risk of infection to staff and patients. The practice employed a contractor for cleaning of the premises. We read the cleaning schedule and saw that monthly audits of the cleanliness of the building were completed.

Equipment

The practice was suitably designed and adequately equipped. The fabric, fixtures and fittings of the building were maintained by the practice. We saw equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED) centrally located and all staff were trained in its use.

All portable electrical equipment was routinely portable appliance tested (PAT) and displayed current stickers which indicated when they had been tested. Single use examination equipment was stored hygienically and was disposed of after use. Other equipment was wiped down and cleaned after use. When equipment became faulty or required replacement, it was referred to the practice manager who arranged for its replacement. Equipment such as the computer based record system were password protected and backed up to prevent data loss.

Staffing & Recruitment

The practice had relevant staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting staff.

Good

Are services safe?

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff 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 enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe.

Monitoring Safety & Responding to Risk

The St James site was located in a purpose built environment which the practice shared with one sub tenant with a small annex which provided additional office and consulting rooms. The maintenance of the building and external grounds was managed by the practice. The health and safety of the building and was managed by the practice. We were shown the systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

There were processes in place for managing risk, for example, the practice monitored repeat prescribing for patients taking medicines which are intended for short term use to avoid dependency. We saw a range of information was available in the practice which provided details of organisations patients or staff could contact if physical health emergencies or mental health crises occurred, either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available. Staff told us how they recognised and responded to changing risks to patients. Staff told us they had recently been trained in what to do in an urgent or emergency situation and about the practice's procedures in such circumstances.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. All staff had recently completed basic life support training and were able to tell us the locations of all emergency medical equipment and how it should be used. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The equipment appeared to be in good working order, designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children. First aid equipment was available on site.

Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. They held a list of the medicines expiry dates and had a procedure for replacing medicines at that time. Staff knew of their location and use for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The practice computer based records had an alert system in place that indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable, for example through poor mobility or where epilepsy was diagnosed. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

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

The practice had an alarm system within the computerised patient record system to summon help. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The document also contained relevant contact details to which staff could refer.. For example, contact details of the computer system supplier in the event of failure.

Good

Are services safe?

The building had a fire system and firefighting equipment, which was in accordance with the fire safety risk assessment. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records which showed staff were up to date with fire training and that regular fire drills were undertaken.

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 treatment approaches. They were familiar with current best practice guidance accessing 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 and these were reviewed when appropriate. For example, high risk patients as identified by the Somerset Risk Tool, had care plans which reflected research based treatment protocols.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, the GPs had an informal meeting each morning which allowed staff to review and discuss best practice.

There were processes for making a referral to specialist or investigative services. The GPs and practice manager confirmed to us urgent referrals were completed on the same day and others within a 48 hour window. We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs informed us the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for patients

Staff from across the practice had key roles in the monitoring and improvement of outcomes for patients. These roles included data input, clinical review scheduling, child protection alerts management and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to monitor and report performance. The practice also participated in local benchmarking run by the clinical commissioning group.

This is a process of evaluating performance data from the practice and comparing it to similar practices in the area. This benchmarking data showed the practice had outcomes comparable to other services in the area.

The practice showed us seven clinical audits that had been undertaken in the last year. 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) a national performance measurement tool. For example we saw an audit in respect of patients who lived with peripheral arterial disease. We saw patients had been identified who fitted the parameters of the audit and that recommendations had been made in respect of monitoring the health of these patients. We also saw an action had been noted to ensure the monitoring occurred. However we did not have any evidence this had happened. We also read an audit relating to polypharmacy (prescribing of several medicines to be taken by one patient) for older patients. This audit had a clear purpose and reaudit process for which an evaluation of results indicated that the practice had been successful in reducing the rate of polypharmacy in the patients group by 9%. We found the quality of the records for the purpose, process and outcomes of audits was variable. Some audits followed the Royal College of General Practitioners (RCGP) guidance and others were a brief record of actions which lacked any details. The audit methods used did not fully demonstrate this was a planned process which had contributed to the quality assurance at the practice.

The patients with long-term conditions we spoke to told us their conditions were well managed and routinely monitored and had found their health conditions had stabilised leading to improved health. We saw monitoring and management programmes for patients with long-term health conditions such as diabetes, anaemia and coronary heart disease, who had regular blood tests, which showed the effective and safe level of the medicine in their system.

The practice used the information they collected for the Quality and Outcomes Framework (QOF) and their performance against national screening programmes to monitor outcomes for patients. For example, practice data indicated 82% of patients on four medicines or more (polypharmacy) had received an annual medicines review. The practice was not an outlier for any QOF (or other national) clinical targets.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. A good skill mix was noted amongst the GPs, with all GPs having specialist interest areas supported by additional qualifications. 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 every five years undertakes a fuller assessment called revalidation. Only when revalidation has been confirmed by NHS England can the GP continue to practice and remain on the performers list with the General Medical Council).

Practice nurses had defined duties they were expected to perform and were able to demonstrate they were trained to fulfil these duties. For example, about the administration of vaccines and cervical cytology screening. Those with extended roles saw patients with long-term conditions such as asthma, diabetes and coronary heart disease and were able to demonstrate they had appropriate training to fulfil these roles.

All staff undertook an annual appraisal which identified learning needs from which action plans were documented. Staff interviews confirmed that the practice was proactive in providing training and funding for relevant courses, for example phlebotomy. The practice was a training practice linked to the Severn Deanery; extended appointment times were offered with trainee GPs and they had access to a senior GP throughout the day for support.

We reviewed how the practice planned the staff team across two sites to safely meet patient needs and found that audits identifying peak times for patient contact were used in staff planning. Staffing levels were set based on the number of patients registered with the practice and varied depending on demand throughout the week. This ensured there was sufficient cover for staff annual leave. All staff were flexible and able to cover shortfalls to ensure patient care. The practice had a detailed induction programme for new staff which included orientation within the practice such as learning the procedures specific to their role, reception skills and also basic training courses.

GP illness and planned absence was managed and the partners covered any shortfalls. We found the practice were proactive with recruitment for new GPs to replace leavers so the practice could continue to provide the same number of appointments to patients. The practice had staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. There was evidence ongoing checks had been made in relation to professional registration and continuing professional development.

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as by the practice manager and each other. They told us they felt skilled and supported in fulfilling their role through a range of learning programmes. The patients we spoke with told us they felt staff were appropriately skilled and knowledgeable in whichever role they provided.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex cases. Blood results, X ray results, letters from the local hospital including discharge summaries, Out of Hours providers and the 111 service were received both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and actioning any issues arising from communications with other care providers on the day they were received. The GP seeing 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. We were told there were no instances within the last year of any results or discharge summaries which were not followed up. The practice had agreed to provide the enhanced services contract. (Enhanced services are services which require an enhanced level of service provision above what is normally required under the core GP contract). For example, the practice participated in the learning disabilities health check scheme and told us 49% of patients with learning disabilities had attended for an annual health check this year.

The practice had well established working arrangements with a range of other services such as the community nursing team, the local authority, local nursing and residential services, the hospital consultants and a range of local voluntary groups. The practice held multidisciplinary team meetings at least three monthly to discuss patients with complex needs, for example, those with end of life care needs or children on the 'at risk' register. These meetings were attended by district nurses, social workers,

palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

The patients we spoke with told us they had been referred quickly to specialists and consultants for further tests or treatment. They also told us how they were referred to voluntary groups for support at times, as well as community nursing services. Patients told us they had received test results promptly and had discussed with GPs and nurses their options for ongoing treatment and support. The records system used by the practice allowed for blood results and information from other healthcare providers to be recorded. For example, discharge letters were scanned onto the system and were available to the clinicians.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, the practice operated a shared care system with the Out of Hours services for patients who may be at the end of their life or those acutely unwell who may need out of hours support. They ensured care plans were updated and accessible. This process promoted continuity of care for patients and reduced hospital admissions. Electronic systems were also in place for making referrals. The practice also had signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours setting with faster access to key clinical information).

The practice had systems in place to provide staff with the information they needed. An electronic patient record was used by all staff to coordinate, document and manage patients' care. All staff were fully trained to use 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

Patients were consulted with to ensure informed decisions and choices were made. All staff were aware of the Gillick competencies. These refer to decisions about whether a child is mature enough to make decisions for themselves and has the ability to be seen alone or with a chaperone rather than with their parents. Where this was the case, we were told patient records would be updated to reflect the current arrangements.

We found that staff were aware of the Mental Capacity Act 2005 and the Children's and Families Act 2014 and their duties in fulfilling it. All the GPs and nurses we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity was an issue, the practice had made guidance available to help staff, for example with making 'do not attempt resuscitation' orders. This stated how patients should be supported to make their own decisions and how these should be documented in the medical notes.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was scanned into the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. We were shown records that confirmed the consent process for minor surgery had been followed.

Health Promotion & Prevention

The practice offered a range of health promotion and prevention to all patients. The promotion and prevention was provided as part of routine GP and nursing appointments and was supported by a range of information available within the practice and on the practice's website. Patient information had a high profile in the waiting area where we observed health promotion display boards, and a patient information area. We observed information was available about health and lifestyle issues such as keeping healthy, living a healthy lifestyle, preventing illness, and preventing any existing illness from becoming worse. Leaflets included information about diet, obesity, smoking, exercise, alcohol, preventing heart disease, cervical screening, and breast screening. Routine health checks were available for patients with diabetes, hypertension and prostate problems and routine and opportunist screening was available for chlamydia, dementia and cervical cancers. The practice also offered health promotion advice and counselling for a variety of issues such as substance and alcohol misuse and contraception.

Good

Are services effective?

(for example, treatment is effective)

The practice offered a variety of screening programmes for patients. It was practice policy to offer all new patients registering with the practice a health check. The GP was informed of all health concerns detected and these were followed-up in a timely manner. This also offered an opportunity to offer health promotion advice and information about screening programmes to patients. We were told the practice lead nurse was proactive in assessing and testing all patients for diabetes as research indicated early intervention reduced health complications in later life. The practice could access a training course for patients with type 2 diabetes which helped patients to identify their own health risks and to set their own goals.

Information advice about treatment options was also available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support via the practice website. The practice was aware of the local initiatives for health improvement from Somerset Council and Somerset Clinical Commissioning Group (CCG) and had accessed them for patients registered with the practice. The practice had numerous ways of identifying patients who needed additional support, and were pro-active in offering additional help. Practice records showed 66% of patients listed on the mental health register had their blood pressure checked since April 2014. The practice had also identified the smoking status of 98% of patients over the age of 16 and actively offered smoking cessation clinics to these patients.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice gave us the up to date information on their performance for all immunisations which was above average for the CCG, and there was a clear policy for following up non-attenders by the named practice nurse.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

The patients we spoke with about the practice told us about the excellent levels of treatment they received and the respect and care they were shown by all members of the practice team. We were told that nursing staff offered support and reassurance to patients when they received treatment. We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey, a survey of patients undertaken with the practice's Patient Participation Group. The evidence from this group showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 92.6% of patients rated the practice as good or very good. Thirteen patients completed Care Quality Commission comment cards which provided us with feedback about the practice. The comments were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

We observed the reception staff treated all patients with dignity and respect when they arrived for appointments. Patients were greeted in their preferred manner and conditions were not discussed in a way that could undermine their privacy. The practice had a self-service booking-in system at reception. The waiting/reception area had a cubicle at one end which was used for confidential discussion. We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. The reception desk was shielded by glass partitions which helped keep patient information private.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard. When patients were called for appointments, the GP or nurse came out to collect the patient and welcomed them by name. Where patients had poor mobility they supported the patient in getting into the treatment room. All patients were seen in private, unless they chose to be accompanied by a partner, parent or chaperone. All consultation rooms were separated from the waiting area and had locks on doors. We did not see any staff enter them unannounced during our inspection.

We were told that the practice supported patients with complex health needs by offering regular follow-up and review appointments, and specialist nurse clinics for long-term health conditions. End of life care was closely monitored in partnership with the community nurses and responsive visits were made as needed.

Care planning and involvement in decisions about care and treatment

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

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 95.5% of practice respondents described their experience of the practice as being good or very good. Patients told us their GP consulted with them about the choices of treatment available to them and how that treatment could be provided.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available, we also saw information was available in the waiting room in alternative languages.

Good

Are services caring?

Patient/carer support to cope emotionally with care and treatment

Notices in the patient waiting room and practice website also signposted patients to a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We saw there was information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that every patient death was notified to the relevant GP and families who had suffered bereavement were called by the practice. The outcome of these calls was either followed by a patient consultation at a flexible time and location to meet the family's needs or signposting to a support service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting patient's needs

We found the practice was responsive to patients' 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. The NHS Local Area Team (LAT) and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. The practice worked as part of the Taunton Federation and was involved in the Somerset Practice Quality Scheme (SPQS). The practice participated in projects such as reducing unplanned emergency admissions and sharing of expertise and resources between the federated practices. We were told the long term goals of the federation were integration of services so that they could be proactive and responsive to the patients, and by sharing resources, offer a wider range of expertise to patients. The SPQS also had a performance reporting function so that the practice monitored its responsiveness to patients.

Longer appointments were available for patients who needed them and those with long term conditions. Home visits were made to local care homes and for patients who could not attend the practice. For younger patients we found appointments were available outside of school hours for children and young patients and the practice had extended hours for those patients who worked. We were told that the nursing team were flexible with clinic appointments and always saw patients who attended clinics without a prior appointment. The practice also acted as the medical officer for a local residential school for approximately 300 children between 11 and 18 years old.

We observed that the waiting area of the practice had distinct seating areas and a variety of seating. For example, there was raised seating for older patients or those with mobility problems. The waiting room was spacious with easy access for patients who maybe wheelchair users, or parents/carers with pushchairs. The practice had a limited supply of toys for younger children. We read in the cleaning schedule for the practice that provision had been made for cleaning the toys.

The practice adopts most of the principles contained in the Gold Standard Framework and meet with the hospice. They had a palliative care register and had regular multidisciplinary meetings to discuss patient and their families' care and support needs. The practice worked collaboratively with other agencies and regularly shared information to ensure good, timely communication of changes in care and treatment.

To promote continuity of care for these patients, all patients had a named GP and appointments were routinely arranged with patients' own GP. The practice also had care plans for all patients over 75 years and patients with long term conditions. We were told the practice had approximately 300 care plans in place for 'at risk' patients and each patient had an allocated care coordinator who reviewed the plan with the patient. We found the practice was working in partnership with the community teams to use telehealth systems which used technology to provide services that assist in the management of long term health conditions. The practice had ten patients who used a telehealth system which enabled individuals to take more control over their own health, by monitoring vital signs, such as blood pressure, and transmitting the information to a telehealth monitoring centre. The results were monitored against parameters set by the individual's GP and if a patient's results were outside these readings then intervention was sought to prevent further deterioration.

We found the practice was proactively involved in the ongoing wellbeing of their patients through use of the Somerset Risk Tool provided by NHS Somerset. This tool identified those patients at most risk of unplanned admissions. This information allowed the practice to manage timely medical interventions.

Information available in the practice promoted good health and wellbeing and the teams worked with patients to promote self-care and independence. Follow up telephone calls were made to patients with long-term conditions to ensure they were following clinical guidance and to remind them to attend their appointments. We were told that it was practice policy to make contact with every patient who had been discharged from hospital. All are discharges reviewed and assesses by GPs. All patients which came under the admission avoidance enhanced service were contacted. All other patients contacted where GP assessed as necessary on clinical, social and support grounds. This

Good

Are services responsive to people's needs?

(for example, to feedback?)

ensured patients had sufficient support for their recovery and to highlight any significant changes in care or treatment that may require input from the practice or linked services such as the community nurse service.

We were told about the local processes for referring patients to specialist care such as the use of the depression scoring system for assessing suicide risk and referral to mental health services. GPs had undertaken training in the Mental Capacity Act 2005 and had completed further research and reading relevant to safeguarding issues. They recognised the need to work closely with the community teams to ensure patients were given the opportunity to make informed consent, or when competence to make informed consent was impaired, then decisions made in the best interests of the patient. We were told 'Do Not Attempt Resuscitation' statements completed for patients at end of life care were reviewed if circumstances changed or at the request of the patient or their representative.

We were told about the participation of two GPs from the practice in the preparation of National Institute for Health and Care Excellence (NICE) guidance.

The staff at the practice were involved in a variety of research projects which were intended to benefit patient care. Patients were informed about the research programmes and consent was sought for their inclusion.

Tackle inequity and promote equality

The practice had suitable facilities to meet patients' needs. All of the practice consulting rooms were on the ground floor and we were told that the branch practice had lift access to the first floor for meeting rooms if patients needed to use them. The practice ensured the environment and facilities were appropriate and that the required levels of equipment were available in all consulting and treatment rooms. For example, the practice had installed electronically operated doors at the entrance to the practice. There was information at the reception desk for staff to use should they need to access an interpreter for a patient whose first language was not English. We also saw information for patients about accessing interpreters. The practice advertised information on notice boards about chaperones being available for patients.

The practice provided equality and diversity training. We observed information relating to equality and diversity around the practice. Patients were asked about their preferences and specifically whether there were any cultural or religious beliefs that would affect some procedures, for example gynaecological procedures or the gender of the consultant. These examples demonstrated how the practice encompassed equality in its' day to day operation.

Access to the service

The practice is routinely open from 8am to 6.30pm on Mondays to Fridays, Wednesday 8.30pm to 1.30pm and 3pm to 6.30pm and Saturday mornings for prebooked appointments. Appointments were available for on the day urgent care and planned appointments. Patients who used the practice told us they were able to contact the practice to make an appointment. Appointments could be made by telephone, in person or by using the practice's new online appointment booking system. Patients were routinely booked with their own GP however the practice ensured GPs of both genders were available. Opening hours were clearly stated on the entrance to the practice, in the practices brochure and their personal and NHS Choice website and had been amended to be flexible and meet the needs of the practice's population. The appointments system was monitored to check both how it worked and where non-attendance occurred. Patients were able to be assessed by a GP, including urgent appointments if needed or telephone consultations and home visits for patients that would benefit from them. A range of appointment slots were available, from short telephone conversation consultations to 10 minute single and 20 minute double appointments. Longer appointments were also available when minor surgery was being provided. The practice could also send text reminders to patients about their appointment.

Staff booked patients with their choice of GP wherever possible, however, on occasions this could not be accommodated. Patients were generally satisfied with the appointments system. Comments received from patients confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. The practice had arranged special clinics to accommodate patients who required an influenza vaccine and we observed these clinics were publicised throughout the waiting area and on notice boards in the entrance to the building.

Listening and learning from concerns and complaints

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice had a system in place for handling complaints and concerns. Their complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. We saw there was a complaint leaflet in reception to help patients understand the complaints system. The practice's complaints procedure was also promoted on their website. Patients we spoke with were aware of the process to follow should they wish to make a complaint. None of the patients spoken with had ever needed to make a complaint about the practice.

We looked at seven complaints from the period 1 November 2013 to 31 October 2014. We found these were satisfactorily handled and dealt with in a timely way. The practice explained in writing what had happened as a result of the issues being raised. The management team at the practice told us they learnt from complaints and made changes to prevent any recurrence. The practice reviewed complaints on an annual basis to detect themes or trends. We looked at the report for the last review and no themes had been identified.

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 manager told us the objectives of the practice were to continue to provide patient centred medical care by continuing to have GP specific patient lists. The priority of the staff was to maintain a good standard of care to patients and to continue to develop additional services to support patient health. The practice had been proactive by replacing an unsuitable branch surgery building with a new purpose built structure. The new building was planned to be 'future proof' and provided a wide range of facilities. There was succession planning in place to ensure continuity of patient care when key staff left the practice so as not disrupt the delivery of the service. The practice had undertaken an analysis of the business to identify the threats and weaknesses of the business and then formulated a business plan to mitigate these. Members of staff from the practice also participated in the local service planning through organisations such as the Clinical Commissioning Group and the Taunton Federation of GP practices.

Leadership, openness and transparency

We were shown a clear leadership structure which had named members of staff in lead roles. For example there was a lead nurse for infection control and the senior partner was the lead person for medicines management. The members of administrative staff we spoke with all told us there was good communication within the practice, with feedback accepted by the partners and the practice manager. Staff confirmed the senior partner and the practice manager were very approachable and actioned any issues that had been raised with them. All staff attended the morning 'huddle' meeting. This was a short informational meeting about the work of the practice for the day. We were told by the GPs there was good communication between the team. They had an informal meeting each morning where any issues or concerns could be raised.

The deputy practice manager took lead responsibility for the day-to-day management of the practice. The practice manager acted as a link between the GPs, staff and patients. The lead practice nurse had responsibility for the nursing team. All the staff we spoke with felt they were well led and supported by the GPs, practice manager and each other, and this made them more confident about proposing new ways of working. We found that staff were encouraged to develop additional clinical skills and roles.

The practice had minuted partner meetings where developments and new guidance were discussed. We found that responsibility and accountability was very clear among the partners of the practice. The GPs in the practice told us they operated an informal monitoring and mentoring system through their daily meetings. The senior partner shared responsibilities with the other GPs. The GPs told us they felt complaints were dealt with following the agreed protocols and they tried to work with the patient and be honest when things went wrong so both patient and practice could learn together.

Governance Arrangements

We saw the practice had a range of governance policies and protocols which covered all aspects of the services it provided and these were routinely reviewed and updated to reflect current guidance.

We discussed the arrangements for clinical governance with the GPs. We found that governance was seen as a universal responsibility and there was an expectation staff would share the responsibility for difficult situations through discussion with others. The staff we spoke with were clear about what decisions they were required to make, knew what they were responsible for and fulfilled their role. For example, one nurse took responsibility for checking emergency medicine expiry dates and we saw this check was carried out.

The practice defined clear lines of responsibility for making specific decisions about the provision, safety and adequacy of care at practice level. The practice nurses we spoke with told us that they always referred patients back to the GPs where medical conditions changed and collectively agreed the best course of action to involve and support the patient.

The practice ensured any risks to the delivery of high-quality care were identified and mitigated before they became issues that would adversely impact on patients. The practice actively sought information in order to improve. We saw the practice routinely gathered feedback from patients via suggestions and questionnaires and used this information to improve. We were told by the practice manager they used audits to inform their own governance

Are services well-led?

Good

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

reporting and practice improvement action plans. The practice's website was well maintained and informative, and provided current and potential patients with information about the practice and improvements.

The GPs we spoke with told us they continually reviewed their patient lists, and individual patient records were reviewed at each appointment. GPs supervised and appraised the nursing team and patient care formed part of these reviews. We observed how the reception staff greeted patients and supported them on their arrival at the practice. All staff were made aware they had a responsibility to ensure patient safety was maintained and where concerns were observed in relation to vulnerable patients, these were reported.

The practice managed risk through policies and operating procedures. We read some policies and observed that they were included as part of the induction programme for newly recruited staff. The staff we spoke with demonstrated a good knowledge of policies and protocols. The practice manager told us that any changes were communicated to staff both informally and at staff meetings to ensure they were implemented as soon as possible. The practice manager told us they monitored adherence to these policies.

Practice seeks and acts on feedback from users, public and staff

The practice was proactive in gaining patient feedback. The survey showed high levels of patient satisfaction with the practice. The survey had been made available to all patients on the practice's website alongside the actions agreed as a consequence of the feedback.

Patients spoke highly of the practice and about how they were involved in their care and treatment. Patients told us they were offered choice and were given information about their preferred course of treatment or support. The practice had established a patient group which was used to inform the improvement and development of the practice. The patients we spoke with reported excellent care and treatment from all staff.

The practice had gathered feedback from staff through staff meetings, appraisal and discussions. We spoke with a range of staff including GPs, the lead practice nurse, the practice manager, and the administrative staff. All the staff we spoke with told us they felt involved in the day to day running of the practice, as well as the longer term functions of the practice. 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 that they had asked for specific training and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistle blowing policy which was available to all staff.

Management lead through learning & improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Performance was also discussed and reviewed at annual staff reviews. Regular appraisal took place and staff had personal development plans. Staff told us the practice was very supportive of training and that they had monthly training afternoons where guest speakers and trainers attended. Staff training included mandatory subjects such as basic life support, fire training and safeguarding children and vulnerable adults. Staff told us they felt supported by the practice manager and the partners in the practice, and that the team were approachable and responded well to any queries raised by administrative staff.

The practice routinely considered improvements to their services and used feedback from the patient participation group. There were measures in place to learn from any incidents that occurred within the practice. Where complaints were received about staff or other aspects of the practice, the practice manager spoke with those involved and offered them support to improve their performance. We were told there were sufficient staff on duty at all times to ensure patient needs were met. We were told the practice manager and the senior partner led the management team well.