The Quantock Medical Centre

Quality Report

Banneson Road,Nether Stowey,Bridgwater,Somerset,TA5 1NW
Tel: 01278 732696
Website: **www.quantockmedicalcentre.gpsurgery.net**

Date of inspection visit: 18 November 2014
Date of publication: 26/03/2015

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Quantock Medical Centre is a rural practice providing primary care services to patients resident in Nether Stowey, Somerset. The practice has a patient population of approximately 3,100.

We undertook a comprehensive announced inspection on 18 November 2014. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector, a CQC pharmacy inspector , a nurse specialist advisor and GP specialist advisor.

Overall the practice is rated as good. This is because we found the practice to be good for providing an effective, caring, responsive and well led service. However the practice was rated as requiring improvement for the safe domain.

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.
- Patients were treated by suitably qualified staff.
- GPs and nursing staff followed national guidance in the care and treatment provided.

Summary of findings

- We found the practice was managed by the practice manager who took responsibility for the non clinical decisions and performance monitoring. However we found the clinical governance systems were not systematic and did not fully demonstrate that the service was robust in monitoring the safety of patient care.

The Quantock Medical Centre demonstrated outstanding practice in several areas

- The practice had a patient centred ethos where medical team saw patients registered with them which gave continuity of care. We were told that GPs gave patients direct contact details to use when in crisis even if this was outside of normal practice hours.
- The practice also reached out to the local community and held health education events in the community hall which benefited the whole community, such as training to use an automated electronic defibrillator for patients who have experienced a cardiac arrest.
- The practice also employed a counsellor and worked with a self employed foot care specialist and self employed fitness and nutrition coach who support and provide services for rural patients who are unable to access services in Bridgwater.

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

The provider must:

- Have established processes in place to assess and monitor the quality of service and includes effective clinical governance processes such as clinical audit and significant events, to assure the safety of patient care.

The provider should:

- Review the checking system for dispensed medicines

We have judged the service to be in breach of the regulation for assessing and monitoring the quality of the service.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Requires improvement

The practice is rated as requires improvement for providing safe services as there were areas where it should make improvements. Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, when things went wrong, reviews and investigations were not thorough enough and lessons learned were not communicated widely enough to support improvement. For example, the practice did not have a formal meeting to review significant events and the practice could not provide any evidence that remedial action had been effective. Although risks to patients who used services were assessed, the systems and processes to address these risks were not fully acted on to ensure patients were kept safe. For example, the evidence of reviews for patients prescribed medicine which required monitoring did not indicate if all recommended checks had been implemented.

Are services effective?

Good

The practice is rated as good for providing effective services. The practice had systems and processes in place to ensure that standards of care were monitored. Best practice guidance was taken in to account and included in operating protocols. The practice manager ensured all staff had access to information about improving outcomes for patients. For example, nurse led health checks 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 practice manager 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 in a targeted way and opportunistically by the practice which engaged well with patients.

Are services caring?

Good

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed

Summary of findings

a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. 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 and continuity of care, with urgent appointments 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.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a vision and a strategy and this was shared by the team. There was a leadership structure and most staff felt supported by management. The practice had a number of policies and procedures to govern activity, which ensured quantitative outcomes, were achieved. However, the practice did not hold regular governance meetings and issues were discussed at ad hoc meetings. There were systems in place to monitor and identify risk but there were not clear clinical pathways in place which mitigated the risk. The practice proactively sought feedback from patients and had an active patient participation group (PPG). All non GP staff had received inductions and received regular performance reviews and attended staff meetings and training events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. The statement of purpose for the practice sets out the key philosophies for the care and treatment of all patients, which ever population group they belong to. 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 nursing staff had a wide range of expertise such as and routinely updated their specialist skills. The practice provides 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 implement a range of monitoring and preventative measures. The practice had sourced chiropody services for patients who were unable to travel to the local town. Monthly multidisciplinary meetings were held with community teams to discuss the most vulnerable patients to enable their optimum care. For patients requiring end of life care and support, a palliative care meeting was held every month with the lead GP. 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 local care homes.

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 ensuring they undertook all necessary training to keep their knowledge up-to-date. These combined skills and knowledge in different areas which complemented one another. Patients' conditions were monitored and reviewed with planned appointments sent directly to them.

We found patients were assessed and signposted to the most appropriate healthcare provision. The practice promoted self-care and offered patients with long term conditions an assessment and education to use telehealth systems for monitoring their condition. All vulnerable patients had a care plan which could include emergency medicines such as antibiotics or steroid therapy. The care plan was made available to the Out of Hours service.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the population group of families, children and young people. 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. 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 had a number of services based within the building which were accessible by patients though self-referral, such as the counselling service and healthy living sessions. 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 using the Gillick competence guidance that the person was competent to make decisions for them self.

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 had emergency appointments each day during extended hours, and a Saturday morning for planned appointments. The practice also provided telephone consultations. The practice provided a fitness and nutrition advisor who held weekly sessions at the practice. 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 and held health promotion events at the weekend which were available to patients who worked.

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 had 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 also included patients who were not necessarily medically vulnerable, but through other circumstance, were on their vulnerable patient register. The practice had sign-posted vulnerable patients to various support groups and third sector organisations. Staff knew how to

Summary of findings

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 and out of hours.

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 in place advance care planning for patients with dementia.The practice had recognised they were sited in a rural location with some social isolation and had employed their own counsellor who provided on site psychological therapies. The practice also sign-posted patients experiencing poor mental health to various support groups and third sector organisations such as local self-help groups run by Somerset Talking Therapies. 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 on how to care for patients with mental health needs and dementia and offered longer appointments to patients with mental health needs.

Summary of findings

What people who use the service say

During the inspection we spoke with eight patients who told us they were very satisfied with the service received. Patients described the practice as excellent and helpful and told us they would recommend the practice to other patients.

The results from the national GP Patient Survey for 2013-14 confirmed what we heard from patients. We found the proportion of patients who would recommend their GP surgery was 94.5%.

The proportion of respondents to the GP patient survey who stated that the last time they wanted to see or speak to a GP or nurse from their GP surgery they were able to get an appointment was 99% of patients. The practice scored 89.2% for their opening hours. The percentage of patients rating their experience of making an appointment as good or very good was 91.3%, and 94.2% of respondents to the GP patient survey gave a positive answer to 'Generally, how easy is it to get through to someone at your GP surgery on the phone?' The proportion of respondents to the GP patient survey who described the overall experience of their GP surgery as good or very good was 91.6%.

Four patients completed our comment cards; 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 treatment.

Patients told us they experienced that staff listened to them and supported them well particularly if they were carers and were looking after relatives who were unwell. We were told that the staff at the practice provide a personalised service and often went out of their way for patients. For example, we were told that patients had received telephone calls outside of normal practice hours from their GP just to check on them. We also heard from patients the GPs would provide patients who are at the end of their lives, with their direct contact number to use if needed. Patients told us that because of the rural area covered by the practice sometimes GPs would deliver medicines to patients. The dispensary at the practice was viewed as a valuable resource for the village.

We were told by patients about the additional health care professionals employed by the practice in order to offer a wider range of care. For example, there was a counsellor employed by the practice. We heard how patients had valued the emotional support and the ability to access counselling at the practice which they found extremely helpful. The practice also employed a fitness and nutritionist instructor who held weekly classes for the community at the practice and a chiropodist who held regular clinics.

The practice had a patient forum that consisted of approximately thirteen members. The practice arranged regular meetings with these members to discuss any improvements that could be made to the practice. We spoke with four representatives who attended the forum. They told us the regular meetings at the practice were really valuable and were attended by a GP and the practice manager. We were told the practice had listened to the group and took their views into account when making decisions about the practice. For example, we heard that there had been an issue with paving in the car park which had been resolved. The group also spoke about the health promotion work they had been involved in within the village. Topics covered included dementia awareness and most recently basic life support and use of an automated external defibrillator. We were told that the last session had prompted patients to raise money to fund annual life support training for the local villages and look at setting up a defibrillator for village use with the parish council.

Areas for improvement

Action the service MUST take to improve

The provider must:

Summary of findings

- Have established processes in place to assess and monitor the quality of service and includes effective clinical governance processes such as clinical audit and significant events, to assure the quality of patient care.

We have judged the service to be in breach of the regulation for assessing and monitoring the quality of the service.

Action the service SHOULD take to improve
The provider should:

- Review the checking system for dispensed medicines.

Outstanding practice

The Quantock Medical Centre demonstrated outstanding practice in several areas:

- The practice had a patient centred ethos where medical team saw patients registered with them which gave continuity of care. We were told that GPs gave patients direct contact details to use when in crisis even if this was outside of normal practice hours.
- The practice also reached out to the local community and held health education events in the community hall which benefited the whole community, such as training to use an automated electronic defibrillator for patients who have experienced a cardiac arrest.
- The practice also employed a counsellor and worked with a self employed foot care specialist and self employed fitness and nutrition coach who support and provide services for rural patients who are unable to access services in Bridgwater.

The Quantock Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector, a CQC pharmacy inspector , a nurse specialist advisor and GP specialist advisor.

Background to The Quantock Medical Centre

The practice is located in a rural village of Nether Stowey in Somerset and provides services to patients living in the Nether Stowey and the surrounding villages. The patient population of 3218 is predominantly white British. The practice is at the heart of the community and offers a patient centred service. The patients see their own GP who is also often the family GP and this gives a continuity of care. The practice also supports patients in residential and nursing care homes.

The Quantock Medical Centre is a dispensing practice with services provided at one location:

Banneson Road,Nether Stowey,Bridgwater,Somerset,TA5 1NW

The practice is routinely open from 8am - 6.30pm Monday to Friday and on Saturdays 8.30am - 10am. There are daily urgent care appointments for patients with an illness requiring same day medical care either at the surgery or as a home visit. The practice is part of the Bridgwater Bay Health Federation.

The patient demographic for the practice is:

Children and young people (0-19 years) 18.5%

Mothers and working adults (20-70 years) 62%

Older people (70 + years) 19.5%

The practice operates as a partnership between two GPs and one salaried GP who work a total of 17 sessions across the week. The practice also employs three practice nurses. The practice does not offer Out-of-Hours care, but provides telephone information to patients about Out-of-Hours and emergency appointments that would be provided by another agency. This information is also available in the practice leaflet and on their website.

The practice has a General Medical Services (GMS) contract and provides specific 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.

Detailed findings

How we carried out this inspection

Before visiting, we reviewed a range of information we had received from other organisations such as the local Healthwatch, the Somerset Clinical Commissioning Group (CCG), and the local NHS England team .

We carried out an announced visit on 18 November 2014 between 9.30am - 5pm.

During our visit we spoke with a range of staff, including GPs, nurses, counsellor, dispensary staff, the 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.

Requires improvement

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, reported incidents, national patient safety alerts as well as comments and complaints received from patients. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents and near misses.

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 significant issues relating to that patient and their care. For example, if a patient had communication difficulties or had missed an appointment.

Learning and improvement from safety incidents

The GPs operated as individual practitioners with autonomy for their list of patients at the practice. They took individual responsibility for making specific decisions about the provision, safety and adequacy of care for their patients.

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We read the record of significant events that had occurred since October 2013 and discussed with the GPs and practice manager the processes in place for preventing recurrence and sharing learning. We were told significant events were sent to the practice manager. The practice manager was able to explain how they were managed and monitored. We tracked seven recorded significant events and saw they had been reported in a timely manner. The GPs we spoke with were aware of their responsibility to complete a significant event form for investigation and take action. We were told significant events were discussed as they arose in order to identify if urgent action would be required. We were told the practice had a system to put in place corrective action immediately following incidents. However the GPs could not confirm the next step in the process by evidencing that appropriate learning had taken place and the dissemination of findings to relevant staff.

The practice did not have regular formal meetings to review significant events, so the practice could not provide evidence to demonstrate how they measured the effectiveness of remedial actions.

We found the GPs at the practice did not follow the same protocols and working practices. We asked the GPs individually about an aspect of treatment and were given different responses of how the issue would be dealt with. For example, we asked about the process for sending tissue samples following minor surgery. The information we were given did not match the protocol in place at the practice which had been developed to meet good practice guidance. We were also told there were no regular clinical meetings between the GPs. However, there was an annual overview of significant events and incidents collated by the practice manager to identify any themes.

The practice manager demonstrated how national patient safety alerts were disseminated to practice staff. The practice manager told us alerts were discussed at the staff meeting. Staff confirmed information was shared and any remedial action agreed and implemented as a team. The staff had regular meetings where they could review themes and change processes if needed. We were given a copy of a staff newsletter which was circulated to all staff which gave information about any changes or updates.

The practice manager demonstrated how they dealt with drug safety alerts and how this impacted on their patients. We were shown the electronic records were searched and any patients receiving the medicine identified. The practice had a summary of prescribing audits which allowed them to monitor how drug safety alerts were affected and informed them that reviews of prescribed medicines took place. The practice manager also received Medicines and Healthcare Products Regulatory Agency (MHRA) alerts and took appropriate action as needed.

Staff told us they would report safety incidents relating to the dispensary to the practice manager. Incidents were recorded together with action taken to avoid a recurrence of the event. We saw an example of one such incident relating to dispensing of medicines in a weekly compliance aid. Medicines are dispensed in a weekly compliance aid to help some patients to take their medicines safely. The action taken to address this had been recorded. However during the inspection we were told there had recently been another incident involving medicines dispensed in a weekly compliance aid. We found that systems in place for

dispensing medicines in this way did not involve a final check by a second person. This could increase the risk of mistakes being made, leading to patients taking their medicines incorrectly.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable patients. Vulnerable patients included looked after children, children on the 'at risk' register, and children whose parents (or households) had drug or alcohol dependencies. Vulnerable patients also included those at risk of experiencing domestic violence, patients with a learning disability, and patients with a diagnosed mental health condition such as dementia and patients in care homes. GPs told us 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 practice's electronic records system had an alert mechanism so staff were made aware there were other important issues to consider when these patients attended appointments. For example, if children had persistently failed to attend appointment for childhood immunisation. The practice also had a system in place to monitor patient attendances at accident and emergency centres and use of Out of Hours services and urgent care centres.

The GPs were trained to level three standard in safeguarding children. The practice ensured all staff had attended safeguarding training corresponding with their role. The GPs were aware of vulnerable children and adults and had good liaison with partner agencies such as the health visitors and social services. The practice manager and GP lead met monthly 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 to share information. Children for whom concerns had been identified had either an individual care plan or a shared plan with the health visitors. 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 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. A chaperone policy was in place and visible on the waiting room noticeboard and in consulting rooms. Chaperone training had been undertaken by all nursing staff.

Patients' individual records were kept on an electronic system. This system allowed all communications about the patient including scanned copies of communications from hospitals to be stored in one place. The system prompted clinicians to look at recently added information about patients so appropriate action could be taken.This system also allowed other healthcare professionals to add clinical records and test results.

Medicines Management

The practice offered a full range of primary medical services and was able to provide a dispensing service to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises.

The practice had a dispensary that was open for a period each morning and afternoon Monday to Friday and on Saturday mornings. We found that medicines were stored securely and were only accessible to authorised staff. However keys for some medicines fridges were not kept securely and could be accessed by unauthorised people. This issue was resolved during the inspection as staff relocated the keys to a secure place. Medicines were stored at the required temperatures. Staff monitored the temperatures of the medicines refrigerators to make sure these medicines were safe to use. The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard operating procedures that set out how they were managed. These were followed in practice. Suitable secure storage was available for controlled drugs, access to them was restricted and the keys held securely. Arrangements were in place for the destruction of out of date controlled drugs and of those returned by patients.

Requires improvement

Are services safe?

Directions in line with legal requirements and national guidance were in place for nurses administering vaccines. We saw up to date copies of these directions. This helped to ensure patients were treated safely.

The practice was signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw evidence that dispensary staff had received training for their role. Staff received annual appraisals and a check of their competence, which helped to ensure they were working to the correct, safe standard.

Safe systems were in place for the generation of repeat prescriptions. Patients had a number of ways to request their repeat prescriptions. We spoke to five patients about the dispensary service. All were very positive about the service they received. Repeat prescriptions had an annual review date. Staff told us they would alert the patient and the doctor that a medicines review was needed, but they were still able to provide a repeat prescription. Dispensary staff told us safeguards were in place to make sure that high risk medicines were identified and regularly monitored. For example they would check that any blood tests that were needed had been done.

Dispensing staff were aware that prescriptions should be signed before being dispensed and there was a system in place in the dispensary enabled this to happen. We saw that dispensed prescriptions awaiting collection had all been signed by the doctor. Some patients registered with the practice were living in a registered care home or had help with their medicines at home. The dispensary provided medicines for these patients in weekly boxes to help them take their medicines safely, the dispensing of these boxes did not involve a final check by a second person.

Cleanliness & Infection Control

We observed the premises to be clean and tidy. There were cleaning schedules in place and cleaning records were kept. Hand hygiene techniques 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 senior nurse 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 senior nurse had carried out audits and any improvements identified for action were completed on time. Practice meeting minutes showed the findings of the audits were discussed. 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.

Equipment

The practice was suitably designed and adequately equipped. The fabric and fixtures and fittings of the building were maintained with regular reviews of the premises undertaken by the practice manager. 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 indicating testing. 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 records checks via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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 they 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 was 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 practice was located in a purpose built environment which was owned by one of the GP partners. The maintenance of the actual building and external grounds was managed by the practice manager. The health and safety of the building was also 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 as an identified health and safety representative.

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 and staff. 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 foreseeable 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 and designated staff members routinely checked this equipment. Other emergency equipment was available in a range of sizes for adults and children. We observed there was first aid equipment available on site when the practice was open. We found the emergency equipment and the defibrillator were in a location easily accessible to staff.

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. The practice held a list of the medicines' expiry dates and had a procedure for replacing medicines at that time. Staff knew where emergency medicines were stored and how to use them, for example, the GPs and nurses understood the medicine protocols for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable, 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

Requires improvement

Are services safe?

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 for staff to refer to. For example, contact details of the computer system supplier in the event of failure.

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 that 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 saw treatment protocols available for nursing staff which reflected NICE guidance. The practice manager demonstrated how the performance of the practice was monitored in respect of implementation of guidance. For example, we were shown how the practice monitored patients who were prescribed specific medicines according to the guidance. The staff we spoke with and evidence we reviewed confirmed these actions were aimed at ensuring that each patient was given support to achieve the best health outcome for them.

The GPs told us they were all general medicine specialists and there were no specific leads in specialist clinical areas such as diabetes, heart disease and asthma. The practice nurses had extended roles which supported the treatment of patients with long term conditions. For example, one nurse had expertise in respiratory care and had worked with patients to achieve their optimum respiratory function. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support.

There were processes for making referrals 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 and the practice operated a daily peer review of all referrals. Interviews with GPs informed us the culture in the practice was that patients were referred based 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 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 told us about the clinical audits that had been undertaken in the last year. The practice manager 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 of patients who had been prescribed specific medicines. Following the audit the GPs carried out medicine reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. However there were no records available which showed how they had reaudited the patients to ensure the success of any changes. The clinical audits were undertaken by the individual GPs in relation to their individual practice.For example, we saw one GP had undertaken an audit of gynaecological referral, but it was unclear if the findings from the audit had been shared with other practitioners or what impact it had for patients. The GPs clearly had a culture of clinical audit to support practice however the audit methods used did not fully demonstrate that this was a planned process which had contributed to the quality assurance of patient care at the practice.

The practice used the information it collected for the Quality and Outcomes Framework (QOF) and its performance against national screening programmes to monitor outcomes for patients. The patients with long-term conditions we spoke to told us their conditions were well managed and routinely monitored and patients told us their health conditions had stabilised. We saw monitoring and management programmes for patients with long-term health conditions such as diabetes, anaemia and coronary heart disease. Patients with these conditions had regular blood tests to monitor whether the level of medicines they were taking remained safe and effective. We found from our discussions with the GPs that although the nurse led monitoring had been completed and recorded, there was no record of the any additional examinations or reviews that may have been recommended. For example, we found

Good

Are services effective?

(for example, treatment is effective)

that the Quality and Outcomes Framework (QoF) for the practice indicated that diabetic patients were not well controlled with medication although they had attended appointments with the nurse for their annual health check. There was no system in place which identified these anomalies.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. 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, on 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 were also able to demonstrate they had appropriate training to fulfil these roles.

Practice staff had annual appraisals 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.

We reviewed how the practice planned the staff team 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. We saw evidence of this in the staff files.

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. There were no instances within the last year of any results or discharge summaries which were not followed up appropriately.

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 as needed and at monthly intervals, 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 whichever professionals were involved with the patients and may be community nurses, social workers, or palliative care nurses. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the meetings to share 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 received

test results promptly, and discussed with GPs and nurses the 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 GPs and nurses.

Information Sharing

The practice used electronic systems to communicate with other providers. For example, the practice operated a shared care system with Out of Hours services for vulnerable patients, those who were at the end their life or for those acutely unwell who needed 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 has signed up to the electronic Summary Care Record. (Summary Care Records provide healthcare staff treating patients in an emergency or out-of-hours 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 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

Patients were consulted about and involved in making decisions relating to their care and treatment. Staff were aware of the Gillick competencies and when to use them. These refer to decisions about whether a child is mature enough to make decisions about their own medical treatment. We were told that where a patient was deemed to be 'Gillick competent', patient records would be updated to reflect this.

We found that staff were aware of the Mental Capacity Act 2005 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.

Patients with learning disabilities and those with dementia were supported to make decisions through the use of care plans which they were involved in agreeing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it. 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 decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. The practice did not use written consent for minor surgery.

Health Promotion & Prevention

The practice offered a range of health promotion and prevention support to all patients. Health promotion and prevention advice was provided as part of routine GP and nursing appointments. The advice was supported by a range of information available within the practice and on the practice's website. 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 on diet, obesity, smoking, exercise, alcohol, preventing heart disease, cervical screening, and breast screening. Routine health checks were available for diabetes, hypertension and prostate problems and routine and opportunist screening was available for chlamydia, dementia and cervical cancers. We were shown how the practice used the opportunity of patients attending for flu vaccination to undertake other diagnostic tests such as blood pressure monitoring. The practice also offered health promotion advice and counselling for a variety of issues such as substance and alcohol misuse and contraception.

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. Information and advice about treatment options was available for patients about mental wellbeing, dementia, managing stress, bereavement and psychological support via the practice website or by the counsellor employed at the practice. The practice was aware of the local initiatives for health improvement from Somerset Council and Somerset Clinical Commissioning Group and had accessed them for patients registered with the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice identified patients who needed additional support, for example, the practice kept a register of vulnerable patients including those with learning disabilities, dementia, mental health conditions and patients in nursing homes. The practice had ensured that the most vulnerable patients had individual care plans (over 60 patients) and used a variety of tools to assess such as the Somerset Risk Tool to ensure plans put into place would be effective to support patient's health. We saw from data provided by NHS England that the practice had a lower than the national average level of emergency admissions and a higher than the national average level of flu immunisations of at risk patients. The practice had a higher than average dementia diagnosis through cognition testing. The practice had also identified 28.5% of patients at the practice who smoked and were able to offer nurse led smoking cessation clinics to of 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 praised the treatment they received and the respect, dignity, compassion and empathy 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 unpleasant or painful treatment. One patient explained to us about the pain they experienced when dressings were changed, and how the nurses always responded positively to them.

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the GP National Patient Survey 2013/2014, a survey of 246 patients undertaken with the practice's patient participation group (PPG). 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 the practice achieved a rating of 84.5% who would recommend the practice. We received four comment cards from patients all of which were positive about the service experienced at the practice. We also spoke with eight patients on the day of our inspection. They 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 medical conditions were discussed confidentially. The receptionists checked in patients for their appointment on arrival. The reception area was at one end of the waiting area which further aided patient privacy.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments. The main phone lines are into reception, as it is a small surgery, the reception staff took all incoming calls. There was a glass partition which is kept closed to aid privacy. A system was in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. However we saw this system in operation during our inspection and noted that patients waiting for appointments could hear discussions at reception. The Practice Manager has discussed with the patient group the request for background music to aid privacy and this is currently being discussed, with a view to a further questionnaire to patients to canvas opinion and support, as a majority of patients have indicated that they would prefer no music at the surgery.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations, however the conversations that took place in the nurse treatment room could be heard in the waiting room. 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.

Care planning and involvement in decisions about care and treatment

Care plans had been formulated for the patients who were over 75 or assessed to be at risk because of their vulnerability. The GPs saw the patients registered with them, this was received well by patients who told us they had a relationship with their doctor and confidence in them. We were told by patients at the practice they 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. Patients we spoke to 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. We heard that patients felt they 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 confirmed these views.

We were given several examples of how patients felt the practice exceeded their statutory duties to patients. For example, a patient spoke with us about a prolonged course of treatment they had received. They emphasised to us that

Good

Are services caring?

the practice had been in contact with their relatives when they were in hospital and offered support. We also heard that GPs routinely delivered medicines to patients on their way home. One patient had only been registered with the practice for a short time but gave a favourable comparison to the practice against their previous surgery, emphasising the caring culture of all the staff. Patients also told us how the practice was embedded in the local community and valued as a community resource.

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. Patients told us that 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.

The patients we spoke with on the day of our inspection gave us examples of how they had been supported emotionally by the practice. We were told how much the patients valued the counsellor.We were told that the practice had a whole practice approach to supporting patients following bereavement. For example, we observed there was a process to share information with staff which prompted various actions such as sending a condolence card. Staff described how they worked with the community nursing team to arrange telephone contact and support visits to ensure patients had the support they needed. We were also 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.

Patients also highlighted to us that staff responded compassionately when they needed help and provided support when required. We were told the GPs took time to follow up patients with personal telephone calls to them. We were also given an example of a patient who was reluctant to receive medical assistance in a crisis and how the GP had visited the patient to assist even though it was outside of normal practice hours.

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

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 patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs. The NHS Local Area Team (LAT) 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. There had been very little turnover of staff during the last three years which enabled good continuity of care and accessibility to appointments with a GP of choice. Longer appointments were available for patients who needed them and those with long term conditions. This also included appointments with a named GP or nurse. Home visits were made to local care homes and for patients who could not attend the practice. For younger patients we found appointments available outside of school hours for children and young patients and the practice had extended hours for those patients who worked.

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 implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from the Patient Participation Group (PPG). For example, we heard that from one member of the PPG who had highlighted inadequate paving around the disabled parking bay. In response to this we saw additional paving had been laid.

The practice had achieved and implemented the Gold Standards Framework for end of life care. 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 enable good, timely communication of changes in care and treatment.

We were told the practice were aware of a higher than average incidence of patients with respiratory diseases. The practice manager told us that the practice employed a specialist respiratory nurse to respond to this need. We reviewed the statistical data for the practice from NHS England as an indicator of how the practice responded to patients with respect of Chronic Obstructive Pulmonary Disease (COPD). We saw the prevalence ratio had been recorded as 1.5 times the national average. The data also showed that confirmation of diagnosis for COPD was 100%, and emergency admissions for COPD was just over half of the national average. We were told the impact made on the health of patients was due to care plans being in place and monitoring of patients.

The dispensary was open on Saturday mornings making it easier for patients to to collect their medicines at a convenient time. Staff told us that the doctor took some patients' dispensed medicines to another village when they held a surgery there, so that patients without transport could collect their medicines more easily. Dispensary staff also told us of a service available for some patients to have their medicines delivered to their home. They were looking at how this could be extended. One patient told us they used the on-line repeat request system and were very impressed with how quickly they were able to collect their repeat medicines. Dispensary staff told us they ordered specific brands of two medicines for two patients because they reacted better to these brands. One person was supplied their pain medicine in a bottle because they could not manage the blister packs.

Information available in the practice promoted good health and wellbeing and the staff 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. This 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 found the practice offered a weekly fitness and mobility session for patients. This session covered issues of weight loss, cardio rehabilitation and healthy lifestyle support for patients and was open to all age groups.

Good

Are services responsive to people's needs?

(for example, to feedback?)

GPs told us they recognised the need to work closely with the community learning disability team and community mental health 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 change or at the request of the patient or their representative.

We found there was no specialist resource within the practice for children and younger adults however, the school nearby housed the health visitors who regularly visited the practice. The practice adhered to and purchased equipment according to National Institute for Health and Care Excellence (NICE) guidance. The practice also offered health screening programmes and was involved in the Child Health Surveillance programme.

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. 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. The practice advertised information on notice boards about chaperones being available for patients.

The practice maintained a register of patients whose circumstances may make them vulnerable; this was flagged on individual patient records. 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 8.30am to 6.30pm on Mondays to Fridays. The practice offered extended hours on Saturday mornings for planned appointments between 8.30am to 10am. 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 offered a choice of GP and the practice ensured GPs and nurses of both genders were available.

Opening hours were clearly stated on the entrance to the practice, in the practices brochure, practice website and NHS Choice website. Opening hours 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 patient were contacted. 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.

Staff booked patients with their choice of GP wherever possible; however on occasions this could not be accommodated. There was a system in place to enable requests for same day appointments to be met. Patients were very satisfied with the appointments system. Comments received from patients confirmed that they could see a doctor on the same day if they needed to and they could see another doctor if there was a wait to see the doctor 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.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

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 three complaints received since 1 January 2014 and found these were satisfactorily handled and dealt with in a timely way. The practice explained in writing in an open and honest way what had happened as a result of the issues being raised. The practice manager team at the practice told us they learnt from complaints and made changes to prevent any reoccurrence. They were able to give examples of this in practice. 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, however lessons learnt from individual complaints had been acted upon.

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 vision and objectives of the practice had been publicised in the statement of purpose for the practice. Staff were able to tell us about the values and philosophy of the practice, which included key concepts such as patient centred care. 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. This was reiterated by both the staff and patients who spoke with us.

Leadership, openness and transparency

The practice manager took lead responsibility for the day-to-day management of the practice and 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 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 did not have a business plan or practice business meetings where developments and new guidance were discussed. We found that responsibility and accountability was not clear among the partners of the practice. There was no partner who lead the service overall and to take important decisions. The partners took responsibility for the medical care of their patient list at the practice whilst other aspects of the service such as the dispensary, were delegated to the practice manager. The practice manager had undertaken an analysis of the service but there was no clear process for decision making and this made planning difficult.

Governance Arrangements

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

We reviewed the arrangements for clinical governance in discussion with the GPs. We found that governance was seen as an individual responsibility, with minimal involvement of other team members. The GPs operated as individual practitioners with autonomy for their list of patients at the practice. They took individual responsibility for making specific decisions about the provision, safety and adequacy of care for their patients. The practice nurses we spoke with told us that they always referred patients back to the GPs where medical conditions changed and responded to direction from the GP for the best course of action to support the patient. The GPs we spoke with told us they continually reviewed their patient lists, and individual patient records were reviewed at each appointment.

We found the GPs at the practice did not follow the same protocols and working practices. We asked the GPs individually about an aspect of treatment and were given different responses of how the issue would be dealt with. For example, we asked about the process for sending tissue samples following minor surgery. The information we were given did not match the protocol in place at the practice which had been developed to meet good practice guidance. We were also told there were no regular clinical meetings between the GPs.

The practice managed risk through policies and operating procedures. 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. We read in staff training records that these policies formed part of the induction programme for newly recruited staff. The staff we spoke with demonstrated a good knowledge of these policies. The practice manager told us that any changes to policies and procedures 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 actively sought information in order to improve and was proactive in gaining patient feedback. 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 that they used audits to inform their own governance 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.

Are services well-led?

Good

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

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 participation 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, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. 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. We looked at three staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training. 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. We saw some evidence that learning was passed on at staff meetings and a newsletter was given to all staff about any changes.

Performance was also discussed and reviewed at annual staff reviews. 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. We were told there were sufficient staff on duty at all times to ensure patient needs were met. We were told that the practice manager led the team well. 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.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because the provider did not have an effective system to enable them to where necessary, to make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to— (I) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and (ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies; (iii) establish mechanisms for ensuring that— (iv) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person.

This section is primarily information for the provider

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The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers People who use services and others were not protected against the risks of inappropriate or unsafe care and treatment because the provider did not have an effective system to enable them to where necessary, to make changes to the treatment or care provided in order to reflect information, of which it is reasonable to expect that a registered person should be aware, relating to— (I) the analysis of incidents that resulted in, or had the potential to result in, harm to a service user, and (ii) the conclusions of local and national service reviews, clinical audits and research projects carried out by appropriate expert bodies; (iii) establish mechanisms for ensuring that— (iv) decisions in relation to the provision of care and treatment for service users are taken at the appropriate level and by the appropriate person.