New Court Surgery

Quality Report

168 Locking Road
Weston Super Mare
North Somerset
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Website: www.newcourtsurgery.nhs.uk

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at New Court Surgery, Weston Super Mare on 17 February 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing well-led, effective, caring and responsive services. It was also good for providing services for the older people, children and families and young people, the working population, people in vulnerable circumstances and with long term conditions and people with mental health problems.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed by a skilled clinical team.
- Patients' needs were assessed and care was planned and delivered following best practice guidance with 7% of the most vulnerable patients being discussed at regular multidisciplinary meetings. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Their care and treatment was provided in a way which protected their privacy.
- Information about services and how to complain was available but not promoted clearly in the waiting areas.
- Patients said they found it easy to make an appointment with a GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had modern, purpose built facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We saw several areas of outstanding practice including:

- The practice had a clear and overarching view of vulnerable patients with 7% of patients registered with the practice having their needs routinely monitored during multi-disciplinary team meetings.
- The practice had worked with the Clinical Commissioning Group (CCG) to implement a localised 'Map of Medicine' system of care pathways to ensure they consistently give the same level of care to patients across the CCG area. (The 'Map of Medicine' provides over 400 patient pathways, based on the most up to date research and clinical evidence available).
- Where urgent home visits were required during normal appointment times the practice had a commissioning arrangement with the Out of Hours service for them to carry out the visit. This reduced the risks to patients in urgent need and prevented possible hospital admissions.

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

Importantly, the provider should:

- Review how information is recorded on the significant events log.
- Review how emergency medical equipment is stored and located.
- Review the information available for patients on the practice noticeboards.
- Review how information about the practices vision and values are shared with all staff and patients.
- Review the frequency of fire evacuation testing to ensure the systems in place work as planned.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe with access to additional staff resources where urgent home visits were required during normal surgery hours.

Are services effective?

Good

The practice is rated as good for providing effective services. Data from the most recent Quality and Outcomes Framework (QOF) returns showed patient outcomes were at or above average for the locality. Staff referred to guidance from National Institute for Health and Care Excellence and used it routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all clinical staff and a plan to implement these for administrative staff this year. Staff worked with multidisciplinary teams from a range of community, voluntary and social care services. Results from the most recent GP survey showed 99% of patients completing the survey said they had confidence and trust in the last GP they saw or spoke with.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed that patients rated the practice higher than others for many aspects of care. We observed a patient-centred culture. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect and maintained confidentiality. Views of external stakeholders were very positive and aligned with our findings. Results from the most recent GP survey showed 91% of patients completing the survey said the last GP they saw or spoke with was good at treating them with care and concern.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Local Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with the staff teams involved and other stakeholders such as midwives and the other practice in location. Results from the most recent GP survey showed 96% of patients completing the survey describe their overall experience of this practice as good.

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. However some staff were unclear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held meetings to review these activities. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was very active and had been fully engaged in the move to the practices new location. Staff had received inductions, regular performance reviews and attended staff meetings and events such as quarterly training days.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data from the most recent Quality and Outcomes Framework (QOF) returns that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

The practice employed two named GPs and a practice nurse with a responsibility for three nursing homes where older people at the registered at the practice lived and provided monthly reviews for those patients with complex needs. The practice nurse provided an annual health review of all residents registered with the practice in addition to reviewing individual residents who may require support for long term condition management. One GP in the practice had lead responsibility for palliative care and helped support patients and carers nearing the end of their life.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and an annual review to check that their health and medication needs were being met. For those people with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD), diabetes and heart failure. The practice had implemented nurse led educational clinics for patients diagnosed with diabetes and involved patients from other practices to help promote improved lifestyle choices. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers.

Summary of findings

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who were on the at risk register. Immunisation rates were very high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we heard evidence from children visiting the practice to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives who were based in the practice, health visitors and school nurses.

Child immunisations were checked regularly by the nursing team with 100% achievement rates for the majority of children in the practice. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments.

Working age people (including those recently retired and students)

Good

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

The practice offered extended hours on Tuesday and Thursday mornings with appointments available from 7:15 am until 6:30 pm and up until 8:15 pm on two days a week. Patients could also choose to 'sit and wait' towards the end of normal surgery hours and would be seen by a GP.

People whose circumstances may make them vulnerable

Good

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

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It had told vulnerable

patients about how to access various support groups and voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours. Information was available to all staff about how to contact statutory safeguarding organisations.

The practice held a register of patients with a learning disability, there were about 100 patients in this category. Patients were invited to the practice for annual health checks through a standard letter offering a longer appointment with a practice nurse followed up with a consultation with a GP where this was required.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The majority of people experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. It carried out advance care planning and made best interest decisions with and for patients with dementia.

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

Summary of findings

What people who use the service say

We spoke with 14 patients visiting the practice and two members of the patient participation group during our inspection. We received 40 comment cards from patients who visited the practice and saw the results of the most recent patient participation group survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice. 96% of patients describe their overall experience of this surgery as good during the 2014 GP patient survey.

All of the comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving compassionate care and treatment, about seeing a GP or nurse of their choice at most visits and about being treated with respect and consideration. Comments from carers also explained about the compassionate support they received in regard of their caring role and the support of the palliative care GP and lead nurse. Comments about the reception team were similarly positive.

We heard and saw how most patients found access to the practice and appointments easy and how telephones were answered after a period of waiting. The most recent 2014 GP survey showed 84% of patients found it easy to get through to the practice and 96% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to make appointments, 90% describe their experience of making an appointment as good.

Patients told us their privacy and dignity was respected at all times both during consultations and in the reception and waiting areas. They told us they found the reception area was generally private enough for most discussions they needed to make. The most recent 2014 GP survey showed 94% of patients said they found the receptionists at this practice helpful. Patients told us about GPs providing extra support to themselves and carers during times of bereavement. Many patients had been attending the practice for over 20 years and told us about how the practice had evolved, how they were always treated well and how the new premises had improved access to treatments. The GP survey showed 90% of patients said the last GP they saw or spoke with was good at giving them enough time and 99% stated they had confidence and trust in the last GP they saw or spoke with.

Patients told us the practice always appeared clean and tidy and the practice had appropriate security measures for extended hours appointments. Online repeat prescription facilities had been added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. The most recent 2014 GP survey showed 96% of patients described their overall experience of this practice as good.

The practice had an active and fully engaged patient participation group (PPG) who met with practice staff regularly and helped make suggestions about improvements to the services offered by the practice. The last PPG report for 2013/2014 had made several recommendations which they told us had been actioned. The groups representatives we spoke with also told us about the responsiveness of the practice and the value they gained from the regular involvement of a GP and the practice manager in their meetings. All PPG members we spoke with told us about the high quality of patient care provided by the practice and about the dignity and respect shown by staff.

Areas for improvement

Summary of findings

Action the service SHOULD take to improve

- Review how information is recorded on the significant events log.
- Review how emergency medical equipment is stored and located.
- Review the information available for patients on the practice noticeboards.
- Review how information about the practices vision and values are shared with all staff and patients.
- Review the frequency of fire evacuation testing to ensure the systems in place work as planned.

Outstanding practice

We saw areas of outstanding practice:

The practice had a clear and overarching view of vulnerable patients with 7% of patients registered with the practice having their needs routinely monitored during multi-disciplinary team meetings.

The practice had worked with the Clinical Commissioning Group (CCG) to implement a localised 'Map of Medicine' system of care pathways to ensure they consistently give the same level of care to patients across the CCG area. (The 'Map of Medicine' provides over 400 patient pathways, based on the most up to date research and clinical evidence available).

Where urgent home visits were required during normal appointment times the practice had a commissioning arrangement with the Out of Hours service for them to carry out the visit. This reduced the risks to patients in urgent need and prevented possible hospital admissions.

New Court Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and other specialists including, a practice manager and a practice nurse.

Background to New Court Surgery

New Court Surgery, 168 Locking Road, Weston Super Mare, North Somerset, BS23 3HQ is one of two GP practices located at 168 Locking Road close to the centre of Weston Super Mare. Both practices moved to their current purpose built location in September 2013, the property is owned by both practices and there is shared responsibility for building maintenance and security.

New Court Surgery has approximately 10,700 patients registered with the practice with a catchment area which includes an area within Weston-super-Mare, there is a boundary outside which the practice cannot accept patients. There are six GPs employed by the practice, two are female and four are male, the hours contracted by GPs are equal to 5.5 whole time equivalent employees. The practice is a newly registered training practice there is currently a female registrar GP completing their training. Additionally there are four nurses employed by the practice equal to 2.54 whole time equivalent employees, and two full time health care assistants are also employed.

The practice population is predominantly White British with an age distribution of male and female patients predominantly in the 45 and above age categories. The average male and female life expectancy for the practice is 80 and 84 years respectively, slightly above the national average. The patients come from a range of income categories with an average for the practice being in the fourth more deprived category. One being the most deprived and ten being the least deprived. About 17% of patients are over the age of 75 years and about 14% under the age of 15 years. Over 91% of patients said they would recommend the practice at the last National GP patient survey.

The CQC intelligent monitoring placed the practice in band five. The intelligent monitoring tool draws on existing national data sources and includes indicators covering a range of GP practice activity and patient experience including the Quality Outcomes Framework (QOF) and the National Patient Survey. Based on the indicators, each GP practice has been categorised into one of six priority bands, with band six representing the best performance band. This banding is not a judgement on the quality of care being given by the GP practice; this only comes after a CQC inspection has taken place.

The practice has a General Medical Services (GMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by BrisDoc and patients are directed to this service by the practice during out of hours. BrisDoc is also contracted to support the practice during normal working hours to provide urgent home visits to patients requiring a GP visit when the practice's GPs are providing appointments to patients.

Detailed findings

Why we carried out this inspection

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

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

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the North Somerset Clinical Commissioning Group and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 17 February 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included four GPs, a registrar GP and a medical student, two practice nurses, two health Care assistants, the reception manager and five administrative and reception staff. We also spoke with the pharmacist from the adjacent pharmacy and a midwife located in the practice. We spoke with 14 patients visiting the practice during our inspection, four members of the patient participation group and received comment cards from a further 40 patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, raising concerns about a child at risk of abuse, highlighting where medicine quantities had been entered incorrectly on the prescription system and managing a data protection matter. Staff we spoke with felt able to raise any concern and knew that following a significant event, the GPs undertook an analysis to establish the details of the incident and the full circumstances surrounding it.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 18 months. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

New Court Surgery had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 18 months and we were able to review these. Significant events were an item on the practices clinical meeting agenda when required and a meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff, however the practice did not currently share all learning across the whole staff group. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked five incidents and saw records were completed in a standard format and timely manner. However the information about the description of the events lacked detail and appeared to rely on the individuals involved to verbally explain the event. We saw evidence of action taken as a result for example, staff training. Where patients had been affected by something that had gone wrong, in line with practice policy, they were contacted, given an apology where appropriate and informed of the actions taken by the practice.

National patient safety alerts were disseminated by the partners and practice manager by email or memorandum to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for, for example lipid-regulating medicines used for the prevention of cardiovascular disease. They also told us alerts were discussed during daily informal meetings to ensure all clinical staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all clinical staff had received relevant role specific training about safeguarding. We asked GPs and nurses about their most recent training. They knew how to recognise signs of abuse in older people, vulnerable adults and children. Administration and reception staff had not all completed recent safeguarding training however, all were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible in the practices policies, on the computer system and in staff information folders in the reception area.

The practice had an appointed dedicated GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. For example, level three learning for safeguarding vulnerable children and similar levels of learning for vulnerable adults. All GPs had received this level of training. All staff we spoke with were aware who had lead responsibility for safeguarding and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients

attended appointments; for example, children subject to child protection plans. Practice staff said communication between health visitors and the practice was good and any concerns were followed up during multi-disciplinary meetings. For example, if a child failed to attend routine appointments, was losing weight or was becoming withdrawn, the GP could raise a concern for the health visitor to follow up and vice versa.

There was a chaperone policy, which was visible in consulting rooms and in the patient information folders in the waiting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. GPs we spoke with told us whenever an intimate patient examination was required patients were offered a chaperone. Patient records we were shown confirmed this.

The practice had a system in place for identifying children and young people with a high number of A&E attendances. The GPs with lead responsibility for safeguarding attended child protection case conferences and reviews and serious case reviews where appropriate. Reports were sent if staff were unable to attend. Similar systems were in place to highlight vulnerable patients and most were included on the practices 2% list of most vulnerable patients. A system had also been put in place to identify vulnerable patients in residential and nursing homes and those being supported by the local authority through community care services. This overarching view of vulnerable patients meant approximately 7% of the patients registered with the practice had their needs routinely monitored during multi-disciplinary team meetings.

Computer based and paper patient records were managed securely with swipe card access to computer held information and secure storage of paper records. Letters and test results were scanned directly onto the patient's computer based record.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice. We saw the practice was following guidance about managing common infections such as respiratory tract and urine infections. This had led to a more targeted use of antibiotic prescribing to reduce resistance to antibiotic treatments.

The nurses and the health care assistants administered vaccines using patient group directions and patient specific directions that had been produced in line with legal requirements and national guidance. We saw that nurses and the health care assistants had received appropriate training to administer vaccines. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked two anonymised patient records which confirmed that the procedure was being followed where blood thinning medicines were prescribed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. New prescription pads and blank prescriptions for printers were held securely however, records were not routinely kept of prescription pad serial numbers when given to GPs or nurses. The practice had established a service for patients to pick up their dispensed prescriptions at locations of their choice and at the adjacent pharmacy and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the premises to be clean and tidy and the same commercial cleaning company was used in both practices at the location. We saw there were cleaning

schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

The practice had a member of staff with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits annually since the practice had moved to their new location.

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

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

The practice had a joint policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal). We saw records that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. We were provided with copies of emails which indicated the actions carried out in response to the last external legionella test report. The building contractor had arranged to remove some pipework and to carry out other actions in line with the last report.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

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

Other equipment such as fire extinguishers were also serviced and tested annually in line with fire safety requirements. The last test had been carried out in August 2014. Fire alarms and emergency lighting were also routinely tested and serviced in line with the practices fire policy. The security alarm was also tested annually.

Staffing and recruitment

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 through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

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

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular 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.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example: there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. The practice nurses paid monthly visits to patients in nursing homes to carry out chronic disease monitoring and to use information gathered to update care plans for the most vulnerable patients. In conjunction with the health visitor and midwife emergency processes were in place for acute pregnancy complications.

A system was in place to ensure staff safety. Each computer had a 'panic' button which when pressed alerted other staff in the practice to a potential problem and who was involved.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all clinical and other staff had received recent training in basic life support. 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) as well as pulse oximeters (A non-invasive method for monitoring a person's oxygen saturation. A sensor device is placed on a thin part of the patient's body, usually a fingertip or earlobe and a measurement taken). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. However, the emergency equipment was located in two separate rooms and was in several bags making it difficult for one person to carry it.

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

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, loss of IT systems, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a utility company to contact if the power supply failed.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. However the fire risk assessment, fire safety policy, the fire policy for patients with disabilities and the fire manual were stored separately making it difficult to have an oversight of all the fire actions required. We spoke with the practice manager about this following our inspection and they told us they would put all documents in one file. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Fire equipment including fire extinguishers and emergency lighting were routinely serviced and up to date, the last check had been carried out in August 2014. However a full fire evacuation of the building had not been completed since taking on the new premises although one had been planned for the near future.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE), the British Medical Journal and from local commissioners. We saw minutes of clinical meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma as well as non-clinical areas such as governance, finance and safeguarding. The practice nurses supported the clinical work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of conditions such as respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

One of the GP partners discussed with us data from the North Somerset Clinical Commissioning Group (CCG) of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients receiving blood thinning medicines which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within two weeks by their GP or according to the individual patient's needs.

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

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and assistant practice manager to support the practice to carry out clinical audits.

The practice showed us 11 clinical audits that had been undertaken in the last two years. Seven of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit about patients diagnosed with cancer following emergency admission to hospital, this showed early diagnosis was lower than the national diagnosis average. As a consequence a plan had been implemented for the GPs to consider common forms of cancer as a diagnosis, undertake a detailed significant event analysis of a recent case and use the learning to improve early cancer detection. Early cancer diagnosis was beginning to improve in the practice as a result of these actions. Other examples included audits to confirm that the GPs who undertook minor surgical procedures were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding atrial fibrillation in relation to stroke risk. Following the audit, the GPs carried out reviews for patients who were identified as being at risk and where no antithrombotic medicines were prescribed an appropriate intervention was provided. GPs maintained records

Good

Are services effective?

(for example, treatment is effective)

showing how they had evaluated the service and documented the success of any changes. The three areas looked at in the audit all showed improved identification and treatments for the patients.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 97% of patients with diabetes had an annual dietary review in the previous 12 months, and the practice met or exceeded all the minimum standards for QOF in diabetes and mental health. This practice was not an outlier for any QOF (or other national) clinical targets.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected both formally and informally on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

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

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. One of the partner GPs had a lead responsibility for palliative care. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register and included those living in residential homes.

The practice also participated in local benchmarking run by the Clinical Commissioning Group CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, the monitoring of patients with hypertension (high blood pressure) and reviewing patients with mental health conditions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw the majority of staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with two having additional diplomas in sexual and reproductive medicine, one with a diploma in family health and one with diplomas in children's health and obstetrics. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses for example, administering vaccinations. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments to enable a clear diagnosis and had access to a senior GP throughout the day for support. We received positive feedback from the trainee and medical student we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines and cervical cytology. Those with extended roles for example, seeing patients with long-term conditions such as asthma, **chronic obstructive pulmonary disease** (COPD), diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Good

Are services effective?

(for example, treatment is effective)

Discussions with management staff showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out-Of-Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook routine audits of follow-ups to ensure inappropriate follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with end of life care needs, children on the at risk register, patients living in residential and nursing homes with complex needs and those patients being looked after by the local authority. 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.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. One GP showed us how straightforward this task was using the electronic patient record system, and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record Emis Web to coordinate, document and manage patients' care. All staff were fully trained on the system and several staff were identified as Emis Web champions to help support other staff using the system. All 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. We saw evidence that audits had been carried out to assess the completeness of records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff for example, with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. We were shown examples of best interest decisions in anonymised patient records and saw how the recorded notes followed guidance in the Mental Capacity Act 2005.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care

plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

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

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures. We saw records which showed 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.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the North Somerset Clinical Commissioning Group (CCG) to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the local area. This information was used to help focus health promotion activity.

It was practice policy to offer a health check with the health care assistant or practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering routine chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed about half of patients in this age group took up the offer of the health check. A GP showed us how patients were followed up within two weeks if they had risk factors for disease identified at the health check and how they scheduled further investigations. Where obesity was identified GPs made referrals to a dietician who was based in the practice to help support patients. Patients diagnosed with diabetes were also referred to the dietician. Other patients were referred to local slimming clubs to help them reduce weight.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed the majority had received a check up in the last 12 months. The practice had also identified the smoking status of 96% of patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. There was evidence these were having some success as the number of patients who had stopped smoking had increased. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 83%, which was in line with others in the Clinical Commissioning Group (CCG) area. There was a policy to offer reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend. There was also a named member of staff responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was significantly above average for North Somerset CCG, and again there was a clear policy for following up non-attenders by the named practice nurse.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital, who were taking multiple medicines or who were nearing the end of their life. An up to date care plan was in place for these patients and the information was shared with other providers such as the out of hour's service. All vulnerable older patients discharged from hospital had a follow-up consultation where it was required. Follow-up consultations were also made during routine appointments.

The practice used the North Somerset Clinical Commissioning Groups 'Map of Medicine' care pathways to

Good

Are services effective?

(for example, treatment is effective)

ensure they consistently give the same level of care to patients to all 25 GP surgeries across the CCG area. (The 'Map of Medicine' provides over 400 patient pathways, based on the most up to date research and clinical evidence available). The practice had been instrumental in setting this system up with the CCG and had localised about 280 pathways. For example, the dementia local pathway had information added about support groups for people with dementia and for people caring for someone with dementia.

The practice employed a practice nurse with a responsibility for three nursing homes which cared for older patients who were registered at the practice. There were two named GPs allocated to the three care homes. The practice nurse provided an annual health review of all residents registered with the practice in addition to reviewing individual residents who may require long term condition management. The practice nurse also carried out monthly health checks on these patients.

The majority of older patients had been offered cognition testing where it was felt appropriate. Most patients with a new diagnosis of dementia had undergone relevant blood testing to check for other conditions. We saw evidence through minutes of multidisciplinary case management meetings having taken place for the most vulnerable patients in this age range. Each patient over 75 years was provided with a named accountable GP.

Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Approximately 600 of the practices patients were diagnosed with diabetes. Weekly GP and nurse led clinics were available to patients diagnosed with diabetes, Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the out of hours system to share information and patient choice with other service providers. These patients also had access to prompt appointments to ensure their needs were met.

The practice had recently run a diabetes educational group involving other practices. This service provided patients with additional information about their diagnosis and also dispelled some of the myths around the condition to enable patients to make better lifestyle decisions about diet and exercise.

Mother, babies, children and young people were supported by a range of relevant services and skilled and knowledgeable staff. A Safeguarding policy was in place and multidisciplinary meetings with both community nurses for adults and the health visitor for children under school age were provided. Where concerns were highlighted patients were placed on either the child protection register or the child in need register. Parent and child records were linked to highlight concerns in families. A designated breast feeding area had been provided in the practice which ensured these patients privacy.

The practice was able to demonstrate almost 100% provision of childhood immunisations. Child immunisations were checked regularly by the nursing team. The practice ensured parents were contacted if a child had not attended the practice for immunisations and there were systems to monitor and follow up children when they did not attend hospital appointments.

The practice provided a chlamydia screening service and had a system of signposting young patients to a local sexual health clinic based in the nearby hospital. The clinic provided patients with sexual health care and contraception advice and treatment in a confidential environment. Information about sexual health was available in the practice however, this information was mainly available via a GP or nurse and not on patient notice boards.

Working age patients were usually provided with their choice of appointment time, with routine practice appointments available from 8:00 am until 6:30 pm. The practice also offered extended hours on Tuesday and Thursday mornings with appointments available from 7:15 am and up until 8:15 pm on Monday and Wednesday evenings. The Choose and Book system was used to offer a choice for patient hospital referrals. The practice provided 'Fit Notes' to patients to help them return to work. Doctors used fit notes to record details of the functional effects of their patient's condition so that individuals and employers could consider ways to help the individual return to work.

Patients in vulnerable circumstances had access to a range of clinics and appointments. Health promotions such as breast screening, cytology and smoking cessation clinics were available to patients. Minor surgery such as joint injections and fitting intrauterine devices was also routinely provided in the practice.

Good

Are services effective?

(for example, treatment is effective)

The practice held a register of about 100 patients with a learning disability. Patients were invited to the practice for annual health checks through a standard letter offering a longer appointment with a practice nurse followed up with a consultation with a GP. (It offered longer appointments for patients with a learning disability which incorporated annual health checks for other conditions such as heart disease). Patients who did not attend were followed up and if necessary this was done through their appointed support worker. Patients with difficulty attending the surgery were provided with a home visit.

Patients experiencing poor mental health who were on the practices mental health, learning disabilities, or dementia register were offered annual health checks; over half had taken up this offer. Patients were provided with a range of services through referrals to locally based services, for example, Child and Adolescent Mental Health Services (CAMHS) and Adult mental health services. The practice worked with patients to try and identify the types and choices of treatment available to them. The practice also made referrals to a local wellbeing service for patients experiencing mental health conditions such as stress, depression and anxiety. The service, which was based in the practice, provided appointments to patients on two days each week. Other services the practice made referrals to include a service which supported patients to bring about positive changes in the lives of people living with disabilities or ill health, or who were isolated, disadvantaged or vulnerable.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey 2013/14, a survey of 67 patients undertaken by the practice's patient participation group (PPG) in 2013/14 and patient comments made on the NHS Choices website. The evidence from all these sources showed patients were satisfied with how they were treated and that this treatment was provided with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 91.6%, 'among the best' for patients who rated the practice as good or very good. The practice was also above average for its satisfaction scores on consultations with doctors and nurses with 90% of practice respondents saying the GP was good at listening to them and 90% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 40 completed cards and the majority 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. Very few comments were less positive but there were no common themes to these. We also spoke with 14 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.

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 in a hygienic environment during examinations, investigations and treatments. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located in a separate area from the reception desk which helped keep patient information private. A touch screen signing in system was available for patients to confirm they had arrived for their appointment. This system facilitated patient privacy. However the practice had inherited a reception desk area which was poorly designed and often led to queues forming. We observed how the reception staff worked hard not to disclose patient information which could be overheard. The practice had recognised the reception area was problematic in terms of patient privacy and were considering enhancements to the reception desk. For example, creating a repeat prescriptions window to ease congestion in this area.

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

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 82% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results. Both these results were in line with or above average compared to other practices in the North Somerset Clinical Commissioning Group area.

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 participation group (PPG) members we spoke with told us about how the practice listened to their comments for improving the practice. They told us about how the GPs and nurses involved them, as patients, in decisions about their treatment and in decisions about

Good

Are services caring?

where they could be best treated. All PPG members commented on the quality of care provided by all GPs and nurses and cited examples of prompt referrals to consultants and specialists.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices on the practices website informing patients this service was available.

We saw evidence of older patients being involved in their care plans and in agreeing these. For some patients their care plans included information about end of life choices, for others they had chosen not to make these decisions for the moment. Similar evidence was available for people with long-term conditions. The children and young people we spoke with during the inspection told us they were treated in an age-appropriate way and were recognised as individuals with their preferences considered. They told us they felt able to talk to the GPs and nurses and that they were treated with kindness and respect.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 87% of respondents to the Patient Participant Group survey said they were made to feel welcome at the practice. The patients we spoke with on the day of our inspection and the comment cards we received stated they were treated respectfully. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. One of the practice staff was a carer's champion. The practice's computer system alerted GPs if a patient was also a carer. We were shown information available for carers on the practices website to ensure they understood the various avenues of support available to them. However, there was very little carer information available on the practices notice boards.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice about how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

The practice had recognised isolation as a risk factor for patients with long-term conditions. Where anxiety and depression were identified they supported patients to access support through a practice based wellness service.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

The NHS England Local Area Team and North Somerset 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. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. Current priorities included, ensuring an integrated health and social care system for adults and children, providing the best possible health care for the patients of North Somerset, within the funding available, reducing health inequalities and improving patient care by ensuring there was easy access to shared, up-to-date and relevant information. The practice had been significant in its involvement of the last point through one of the GPs involvement in the project.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, providing improved information on the patient information screens in waiting areas, providing staff training about the needs of disabled patients, ensuring waiting areas were accessible for patients with disabilities and improving hand hygiene facilities.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, the unemployed, carers and patients experiencing poor mental health. Longer appointment times were available, appointment times were available from early morning until mid-evening and patients could use a 'sit and wait' appointment system.

The practice had access to online and telephone translation services and their website could be translated into most non-English languages. The practice had a population of approximately 95% English speaking patients.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the training and that equality and diversity was regularly discussed at staff appraisals and team events. Further training in this area was being prioritised for all staff who had not completed this training.

The premises and services had been adapted to meet the needs of patient with disabilities. There were parking spaces for patients with disabilities and level access into the practice. Automatic opening doors assisted access into the building and there was sufficient space for wheelchair users and parents with pushchairs to manoeuvre safely. A lift was available to each floor in the building. There were accessible toilets and baby changing facilities, a breast feeding room was also provided. All consulting and treatment rooms were on one level and only a short distance from the waiting areas.

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

The practice maintained a register of people who may be living in vulnerable circumstances and had a system for flagging vulnerability in individual records. Patients were easily able to register with the practice, including those with "no fixed abode" care of the practice's address. People not registered at the practice for example, those on holiday were able to access appointments through a 'sit and wait' service.

Access to the service

Appointments were available five days a week between 8:00 am and 6:30 pm. The practice offered extended hours on Tuesday and Thursday mornings with appointments available from 7:15 am until 6:30 pm and up until 8:15 pm on Monday and Wednesday evenings. Patients could also choose to 'sit and wait' towards the end of normal surgery hours and would be seen by a GP.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

Longer appointments were also available for 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 three local nursing homes by a named GP and practice nurse and to those patients who needed one. Where urgent home visits were required during normal appointment times the practice had a commissioning arrangement with the out of hours service for them to carry out the visit. This reduced the risks to patients in urgent need and prevented possible hospital admissions.

Patients were generally satisfied with the appointments system. They confirmed they could always see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment for their child and an appointment was provided a little later that morning.

Home visits for older people and people with long-term conditions were available where needed and longer appointments if required were also available. Families, children and young people were provided with appointments outside of school hours. The premises were suitable for children. The practice had an understanding of student population and working age population and services reflect this with extended opening hours. An online booking system was available and we were told by patients it was easy to use.

Patients whose circumstances may make them vulnerable had access to longer appointments for those that needed them, flexible services and appointments, including for example, avoiding booking appointments at busy times for patients who may find this stressful. Patients experiencing poor mental health or those who had longer term mental health needs were provided with longer appointments for those that needed them. Annual health checks were also provided.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system in the patient information files in the waiting rooms and on the practices website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at 12 complaints received between September 2013 and September 2014 and found these were satisfactorily handled, dealt with in a timely way and had been part of the annual review of complaints. Where an apology was required the practice had written to patients and where more detailed investigations were needed these had been carried out. Lessons had been learnt from complaints. For example, where a complaint was received about online prescribing, the practice had apologised to the patient and made clearer information available about online prescribing on their website

The practice reviewed complaints annually to detect themes or trends. The majority were responded to and resolved within two weeks. We looked at the report for the last review and no clear themes had been identified. However, lessons learned from individual complaints had been acted on.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. These values were clearly promoted on the practices website and intranet. However they were not available in the patient or staff areas. The practice vision and values included, continuity of patient care, GPs acting as the patient's advocate, teamwork across the practice and partnership with other services, effective chronic disease management delivered in conjunction with the practice nurses and to be informed and involved in all aspects of primary health care.

We spoke with the clinical staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these. Non-clinical staff were less clear about these values but were clear in their role in delivering patient centred care. The practice acknowledged the vision and values were not routinely discussed at meetings but that they formed the basis of individual discussions during staff appraisals.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at 28 of these policies and procedures and most staff told us they had read the policies relevant to their role during their induction and knew where they were located. All policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and the senior partner was the lead for complaints and information about the Care Quality Commission. All members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, stroke prevention in atrial fibrillation therapy, review of two week wait with suspected cancer referrals and a review of patients with coeliac disease. Actions taken in response to these audits included clearer identification of the levels of risk of stroke patients, increased use of the two week wait service to promote earlier diagnosis and better lifestyle and dietary advice and regular condition reviews respectively.

The practice had arrangements to identify, record and manage risks. The practice manager provided us their risk log which addressed a wide range of potential issues, such as loss of services, environmental problems and staff illness. We saw the risk log was discussed at meetings and updated in a timely way. Risk assessments had been carried out where risks had been identified and action plans had been produced and implemented. For example, relocating the practice to accommodate a larger patient population and to mitigate concerns about building maintenance and accessibility.

The practice held quarterly meetings in which governance was discussed. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every three months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment policy, induction policy for different staff roles and management of sickness which were in place to support staff. We were shown the

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computer based information that was available to all staff, which included sections on equality, harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Overall the staff we met spoke positively about the leadership within the practice and how they were accessible, open and transparent in the way they supported all employees in the practice. The practice acknowledged there had been some staff concerns following the move to their new location but these had now been resolved. We saw that staff with lead responsibility within the practice took their roles seriously and ensured staff were kept informed of improvements in the way they worked. We observed the office functions within the practice were well led by an enthusiastic management team who communicated well with staff at all levels.

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

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. We looked at the results of the annual patient survey and saw 96% describe their overall experience of this surgery as good. We reviewed comments sent to the practices website from patients between December 2014 and February 2015, which had a common theme of praising the practice staff. The practice manager told us these had been shared with staff informally and would be shared formally at the next staff away day.

The practice had an active patient participation group (PPG) which had steadily increased in size. The PPG included representatives from various population groups including the working population and older patients. The PPG had carried out annual surveys and met every quarter. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website.

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. One member of nursing staff had asked for specific training around ear irrigation and this had happened. Other staff gave us examples of where they had expressed an interest in attending learning events and having subsequently been provided a place on the event. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four clinical staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was supportive of training and that they had staff training sessions quarterly where guest speakers and trainers attended.

The practice was a GP training practice with one registrar GP in post at the time of our inspection. The registrar had experience in hospital medicine and was spending a period with the practice to gain experience in family medicine. The registrar told us they were supported by two GPs in the practice and could always access a GP for advice or opinion. They told us about the useful practice intranet system and the information it provided as well as other resources available to them for example, journals and health publications. They were very complimentary about the support they received and the way the practice was managed.

The practice had completed reviews of significant events and other incidents and shared with the staff involved at meetings this ensured the practice improved outcomes for patients.