Dr Burton, Dr Sells, Dr Edwards, Dr Shackleton

Quality Report

Lyngford Park Surgery
Fletcher Close
Taunton
Somerset
TA2 8SQ
Tel: 01823 333355
Website: www.lyngford.co.uk

Date of inspection visit: 27 May 2015
Date of publication: 02/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Lyngford Park Surgery on 27 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for older patients, patients 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 and people experiencing poor mental health (including people with dementia).

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.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Health promotion and prevention was a priority for the practice.
- Patients said they were treated with compassion, dignity and respect by all staff and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent and triage appointments available the same day.
- The practice had good 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 areas of outstanding practice:

- We saw evidence of the practice providing health promotion in the community. For example, the registered manager partner provided a "When things go wrong below the belt" talk to approximately 30 men about testicular cancer, erectile dysfunction and prostate problems. Practice staff attended a local 'Fun Day' and 'pamper' evening and provided blood pressure checks and blood oxygen saturation checks using pulse oximeters to people attending the events. The GPs also provide brief medical articles for parish magazines in support of health promotion; recent articles included information about; hay fever; chronic pain and seasonal diabetes advice.
- The practice had implemented a "Year of Care" approach for diabetic patients. Patients are given test results in advance of their appointment with the lead diabetic nurse which gave them time to think about their progress before their care planning appointment and enabled them to be more involved in their care and treatment.

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

Importantly the provider should;

- Ensure all staff are clear about when to obtain written consent and how to record it.
- Review systems for recording training to ensure all staff records are up to date.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

The practice is rated as good for providing effective services. Data showed patient outcomes were at or above average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked regularly with multidisciplinary teams.

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 several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information for patients about the services available was easy to understand and accessible. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

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 Area Team, the Taunton and Deane federation and Somerset 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

Summary of findings

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 staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people. Nationally reported data showed 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.

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 a structured 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.

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 had a high number of A&E attendances. Immunisation rates were relatively 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 saw evidence 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, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age 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

Summary of findings

a full range of health promotion and screening that reflects the needs for this age group. The practice had previously offered NHS Health Checks to all its patients aged 40 to 75 years, this was now a contracted out service in the Somerset area.

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 homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and 95% of these patients had received a follow-up. It 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.

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). 100% 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 for patients with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and 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. Staff had received training on how to care for people with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with eight patients visiting the practice during our inspection, two members of the patient participation group and received 42 comment cards from patients who visited the practice. We saw the results of the last Patient Participation Group report dated March 2015. The practice also shared their findings from the current 'friends and family' survey for the practice. 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 National GP patient survey published on 8 January 2015 and the Care Quality Commission's information management report about the practice.

All comments from patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving good care and treatment, about seeing the same GP when requested and about being treated with respect, compassion and consideration. Other comments included statements of how responsive the practice was in providing appointments with their preferred GP or nurse, compliments about the appointment system, doctors helping patients to understand their condition and how they felt listened to. The patient participation group members we met spoke positively about the engagement shown by the recently appointed practice manager and about how responsive the practice was to their suggestions for improvement.

We heard and saw how patients found access to the practice and appointments easy and how telephones were answered after a brief period of waiting. Comments from the National GP Patient Survey indicated 87% of patients saying it was easy to get through by telephone compared to the Clinical Commissioning Group (CCG) average of 77%. The most recent GP survey showed 94% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to get appointments.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was generally private enough for most discussions they needed to make. We saw 94% of patients said they found the receptionists at this practice helpful compared to the CCG average of 89%. Patients told us about GPs supporting them at times of bereavement and providing extra support to carers. A large number of patients had been attending the practice for many years and told us about how the practice had grown, they said they were always treated well and received good care and treatment. The GP survey showed 93% of patients said the last GP they saw or spoke with was good at giving them enough time and treating them with care and concern.

Patients told us the practice was always kept clean and tidy and periodically it had been refurbished and updated. Patients told us that during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. Information from the National GP Patient Survey showed 99.6% of patients described their overall experience of this practice as good.

Areas for improvement

Action the service SHOULD take to improve

- Ensure all staff are clear about when to obtain written consent and how to record it.
- Review systems for recording training to ensure all staff records are up to date.

Summary of findings

Outstanding practice

- We saw evidence of the practice providing health promotion in the community. For example, the registered manager partner provided a “When things go wrong below the belt” talk to approximately 30 men about testicular cancer, erectile dysfunction and prostate problems. Practice staff attended a local ‘Fun Day’ and ‘pamper’ evening and provided blood pressure checks and blood oxygen saturation checks using pulse oximeters to people attending the events. The GPs also provide brief medical articles for parish magazines in support of health promotion; recent articles included information about; hay fever; chronic pain and seasonal diabetes advice.
- The practice had implemented a “Year of Care” approach for diabetic patients. Patients are given test results in advance of their appointment with the lead diabetic nurse which gave them time to think about their progress before their care planning appointment and enabled them to be more involved in their care and treatment.

Dr Burton, Dr Sells, Dr Edwards, Dr Shackleton

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 a practice manager specialist advisor. The inspection was observed by a member of the National Audit Office as part of their review of the Care Quality Commissions new structure and approach to inspections.

Background to Dr Burton, Dr Sells, Dr Edwards, Dr Shackleton

Dr Burton, Dr Sells, Dr Edwards, Dr Shackleton, Lyngford Park Surgery, Fletcher Close, Taunton, Somerset. TA2 8SQ is located close to the centre of Taunton. The premises were purpose built in 1986. The practice has approximately 5,770 registered patients, this figure is growing monthly. The practice accepts patients from an area in the northern parishes of Taunton and surrounding villages.

There are four GPs and a team of clinical staff including practice nurses and a health care assistant. Two GPs are female and two are male, the hours contracted by GPs are equal to 3.1 whole time equivalent employees. Collectively the GPs provide 28 patient sessions each week. Additionally the three nurses employed equal to 1.06 whole time equivalent employees and a health care assistant equal to 0.56 whole time equivalent employees employed. Non-clinical staff included secretaries, support staff and a small management team including a practice manager and deputy practice manager. The practice is a registered training practice with the Severn Deanery and supported a Registrar GP and a foundation programme (F2) doctor at the time of our inspection.

The practice population ethnic profile is predominantly White British with an age distribution of male and female patients' equivalent to national average figures. There are about 4% of patients from other ethnic groups, the majority being patients from Poland The average male life expectancy for the practice area is 74 years compared to the Taunton average of 79, across the Somerset Clinical Commissioning Group area the female life expectancy is 84 years. The practice population has a particularly high incidence of cancer with 81 diagnosed cases compared to an expected value of 41. Similarly there is a particularly high incidence of chronic obstructive pulmonary disease (COPD) with 120 diagnosed patients compared to an expected number of 90. There is also a high proportion of adults registered with the practice who smoke (24%) compared to the Taunton average of 15%. Services are available to support patients in the groups mentioned.

The National GP Patient Survey published in January 2015 indicated just over 90% of patients said they would recommend the practice to someone new to the area. This was above the Somerset Clinical Commissioning Group average of 83%. Local Public Health statistics (January 2014) demonstrate that Lyngford Park Surgery has a high level of social deprivation, the Index of Multiple Deprivation being 23.2 in compared to a Somerset average of 16.9. Approximately 49% of the practices population live in the 20% most deprived neighbourhoods in Somerset.

Detailed findings

The practice has a General Medical Services (GMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for people with dementia and minor surgery services. It also provides an influenza and pneumococcal immunisations enhanced service. These contracts act 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 South Western Ambulance Service NHS Foundation Trust and patients are directed to this service by the practice during out of hours.

Why we carried out this inspection

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

How we carried out this inspection

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

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to 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 Somerset Clinical Commissioning Group (CCG) 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 27 May 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included three GPs, the registrar GP and F2 trainee, one practice nurses, the health care assistant, the practice manager and their deputy and three administrative and reception staff. We spoke with two members of the patient participation group, eight patients and received comment cards from a further 42 patients. We also spoke with the CCG pharmacist who was visited the practice during the inspection.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, concerns about a patient being incorrectly booked in for an appointment.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last year. The records were detailed and linked to information in the individual patients' records. 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

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 12 significant events that had occurred during the last 15 months and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly 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. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a comprehensive and timely manner with links to information in the individual patients' records. We saw evidence of action taken as a result and that the learning had been shared for example, the importance of checking the patient's record in detail to avoid using the wrong information. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager to relevant 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, an eye drops medication alert which had been cascaded from the Clinical Commissioning Group to GPs and relevant clinicians. They also told us alerts were discussed at weekly clinical meetings and staff meetings to ensure all 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 staff had received relevant role specific training about safeguarding vulnerable adults. However these were some gaps in the training records of two nurses and the health care assistant for this training. We asked members of medical, nursing and administrative staff about their most recent training and knowledge of safeguarding. Staff explained how they would recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible on the practices intranet and also on staff noticeboards in all consulting and treatment rooms.

The practice had appointed dedicated GPs with lead responsibility for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were 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 and adults living in vulnerable circumstances. There was active engagement in local safeguarding procedures and effective working with other relevant organisations such as health visitors and the local authority.

Good

Are services safe?

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

GPs were appropriately using the required codes and alerts on their electronic case management system to ensure risks to children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of meetings where vulnerable patients were discussed. We also saw the practice in partnership with the Clinical Commissioning Group pharmacist had systems for reviewing repeat medicines for patients with co-morbidities and multiple medicines.

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 policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature.

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.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, patterns of analgesic, antibacterial items and bronchodilators (medicines used to help make breathing easier) prescribing within the practice.

There was a system in place for the management of high risk medicines such as warfarin and other disease modifying drugs, which included regular monitoring in accordance 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.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). With help from the Clinical Commissioning Groups pharmacist they carried out regular audits of the prescribing of controlled drugs. The CCG pharmacist told us the practice was responsive to the outcomes of audits and routinely reviewed their practice based on the audit results. Staff we spoke with told us they were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw the health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses and the health

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

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

The practice had established a service for patients to pick up their dispensed prescriptions at local locations 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. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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

The practice had a 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 for each of the last three years and that any improvements identified for action were completed on time. Minutes of practice meetings showed that the findings of the audits were discussed.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms.

The practice had a policy and risk assessment for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). The practice had undertaken a risk assessment for legionella and had decided that the risk was sufficiently low to make formal testing unnecessary.

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 that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was completed in January 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, weighing scales, spirometers, blood pressure measuring devices, a centrifuge and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. 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 the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). However as part of a recent audit of staff files the practice had identified one of their nurses did not have a current DBS check. The practice manager risk assessed the situation, immediately applied for a DBS check and made a decision that the nurse should not work with

patients until an updated check was received and their indemnity insurance renewed. We were provided with evidence which showed the nurse was not currently seeing patients.

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 showed us records to demonstrate that actual staffing levels and skill mix met 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 the practice manager was the 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. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this for example, covering GP absences and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that 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. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for patients receiving medication for mental ill-health and those with other vulnerable circumstances.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date.

Emergency medicines were easily accessible to staff 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 and equipment were within their expiry date and suitable for use. All the medicines and equipment we checked were in date and fit for use including those in GPs bags.

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, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of utility companies to contact if the heating, lighting and water systems failed. The plan was last reviewed in 2015

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms and a small reference library was available in the practices meeting room. We discussed with the practices GPs and nurses how NICE guidance was received into the practice. They told us this was downloaded from the website and the monthly NICE newsletter and disseminated to staff by a lead GP. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. We saw the NICE care pathways were 'pinned' to the GP registrar's web browser during consultations to help facilitate patient diagnosis and advice.

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

The GPs told us they lead in specialist clinical areas such as heart disease, respiratory conditions and minor surgery and the practice nurses supported this 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 review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened routinely.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

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

The practice showed us 14 clinical audits that had been undertaken in the last three years. The majority of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit about anticoagulant use in patients diagnosed with atrial fibrillation. The aim of the audit was to establish whether the anticoagulant was appropriate for their clinical picture. The first audit showed 37% of patients were receiving new oral anticoagulants (NOAC's). Following two further audit cycles and reviews of prescribing this figure had increased to 56%. The prescribing of other anticoagulants such as aspirin had decreased markedly and the number of patients having strokes had been reduced. Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

Good

Are services effective?

(for example, treatment is effective)

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 the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF, Somerset Practice Quality Scheme (SPQS data and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 76% of the total clinical QOF target in 2014, which was 16.5 points below the national average and was accounted for by the Somerset Clinical Commissioning Group (SCCG) initiative of SPQS which did not include some QOF areas. Specific examples to demonstrate this included, performance for diabetes related indicators were similar to the national average. The percentage of patients with hypertension having regular blood pressure tests was similar to the national average. Performance for mental health related and hypertension QOF indicators were similar to the national average. The dementia diagnosis rate was comparable to the national average. The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

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

The practice's prescribing rates were also similar to expected national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. It 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. 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 to approximately 3% of the overall practice population.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups such as those diagnosed with a learning disability and patients with serious head injuries living in a nearby nursing home. Structured annual reviews were also undertaken for people with long term conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart failure.

The practice is part of a shared care programme for substance misuse and patients have a quarterly structured medical and medicines assessment with their named GP together with the substance misuse worker from Turning Point (a national provider of substance misuse services in England and Wales). All patients with a mental health diagnosis had access to a named GP for urgent care who referred them to the crisis team if there were significant concerns. Patients who were struggling but didn't require crisis intervention are given a card for the out of hours emergency help line which included telephone numbers to facilitate their contact with mental health support services and out of hours services.

The practice participated in local benchmarking run by the (SCCG). This is a process of evaluating performance data

Good

Are services effective?

(for example, treatment is effective)

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, in the prescribing of antibacterial items.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with three having additional diplomas in sexual and reproductive medicine and family planning, 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 since the appointment of the current practice manager 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, phlebotomy and vaccine injections. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments of 30 minutes and had access to a senior GP throughout the day for support. We received very positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology and diabetes. 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.

Staff files we reviewed 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 these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. 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.

Emergency hospital admission rates for the practice were similar to expected at 16.9 compared to the national average of 13.6. We saw that the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit 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 patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate. In addition the practice regularly met with the organiser of 'Equilibrium', a local self-support group for patients with bipolar disorders.

The practice had recently started collaborating with another local GP practice to share information and resources. There was a future plan to explore using staff skills and specialisms across the two practices to provide greater accessibility for patients to a wider range of services. The practice manager worked in both practices and was pivotal in driving the collaborative ways of working.

Good

Are services effective?

(for example, treatment is effective)

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. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

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

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled electronic and scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that checks had been carried out to assess the completeness of these 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. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a protocol to help staff. For example, with making do not attempt resuscitation orders. The protocol also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. The practice kept records and showed us the majority of care plans had been reviewed in last year. 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 the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for personal examinations, a patient's verbal consent was documented in the electronic patient notes with a record of the reasons for the examination. In addition, the practice obtained written consent for significant minor procedures. However not all staff we spoke with were clear about when to obtain written consent and how to record it.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

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

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

The practice had previously offered NHS Health Checks to all its patients aged 40 to 75 years, this was now a contracted out service in the Somerset area. We were shown the process for following up patients within immediately if they had risk factors for disease identified at the health check and how further investigations were scheduled.

Good

Are services effective?

(for example, treatment is effective)

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of all 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 during the current course at four weeks after their quit date was 64%, which was above average compared to neighbouring practices and national figures. 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 the cervical screening programme was 85%, which was slightly above the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A member of staff had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

We saw evidence of the practice providing health promotion in the community. For example, the registered manager partner provided a "When things go wrong below the belt" talk to approximately 30 men about testicular cancer, erectile dysfunction and prostate problems. Practice staff attended a local 'Fun Day' and pamper evening and provided blood pressure checks and blood oxygen saturation using pulse oximeters to people attending the events. The GPs also provide brief medical articles for parish magazines in support of health promotion; recent articles included information about; hay fever; chronic pain and seasonal diabetes advice.

The practice had implemented a "Year of Care" approach for diabetic patients. Patients are given test results in advance of their appointment with the lead diabetic nurse which gave them time to think about their progress before their care planning appointment and enabled them to be more involved in their care and treatment. Patient involvement for this practice was noted to be 8% higher than the CCG average of 78% and a further 3% higher than the national average.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, childhood immunisation rates for the vaccinations given to under twos ranged from 93.8% to 100% and five year olds from 94.4% to 100%. These were above the CCG averages.

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 published on 8 January 2015, a survey of patients undertaken by the practice's patient participation group (PPG) and the current friends and family questionnaire. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 90.2% '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 average for nurses. For example:

- 95% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87%.
- 93% said the GP gave them enough time compared to the CCG average of 86% and national average of 85%.
- 99.6% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.8% and national average of 92.2%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 42 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. Just two comments were slightly less positive but there were no common themes to these. We also spoke with eight 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 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 that 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 away from the reception desk and was in a separate area of the practice which helped keep patient information private. The waiting area was in a separate area from reception and the electronic signing in screen was away from the reception desk This prevented patients overhearing potentially private conversations between patients and reception staff. Additionally, 94% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 87%.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff. We were shown an example of a report on a recent incident that showed appropriate actions had been taken. There was also evidence of learning taking place as staff meeting minutes showed this had been discussed.

There was a clearly visible notice in the patient reception area and on the practices website stating the practice's zero tolerance for abusive behaviour. Staff told us that referring to this had helped them diffuse potentially difficult situations.

Patients whose circumstances may make them vulnerable and those experiencing poor mental health were able to access the practice without fear of stigma or prejudice. Staff treated people from these groups in a sensitive manner, and dealt sympathetically with all groups of people.

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:

Good

Are services caring?

- 91% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 86% and national average of 82%.
- 86% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 75%.
- 90% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 83%.
- 78% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 81% and national average of 78%.

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.

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 patents this service was available. We also saw notices in Polish explaining about antibiotic prescribing in the CCG area as this was a known discussion point with many of these patients.

We saw evidence of care plans for older patients which showed patient involvement in agreeing these including information about end of life planning. We saw similar information for patients with long term conditions where they were on the most vulnerable patients list. From the patients we spoke with we heard evidence that children and young people were treated in an age-appropriate way and were recognised as individuals with their preferences considered.

Patient/carer support to cope emotionally with care and treatment

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

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

Notices in the patient waiting room and the practices website also told patients how to access a number of local and national support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. One of the practice staff had a lead responsibility for carers and had provided carer specific information on a reception area noticeboard. Patients were referred to Compass Care for further support in their caring role.

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 on how to find a support service. The practice also provided a range of information to support patients at times of bereavement including counselling services such as 'Talking Therapies' and 'Cruise', and suicide bereavement services.

For older patients and those with mental health conditions we saw evidence the practice recognised isolation as a risk factor and provided support to address this such as referring patients to Talking Therapies counselling services.

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. For example, through the provision of clinics such as for diabetes, smoking cessation, diet and immunisations and vaccinations.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population.

The practice had met with the Public Health team from the local authority and the CCG to discuss the implications and share information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA). The JSNA pulls together information about the health and social care needs of the population in the local area. This information was used to help focus services offered by the practice. For example encouraging communities and individuals to take more control of and responsibility for their own health and wellbeing. Other examples were developing joined-up person-centred care, transforming the effectiveness and efficiency of urgent and acute care across all services and sustaining and continually improving the quality of all services. These points were integral to the practices vision and aims.

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, improving the appointments system, improving waiting times when attending appointments and improving confidentiality in the reception area. The PPG were currently working with the practice to identify ways of reducing the number of patients who fail to attend appointments. There had been 15 unattended appointments in the week prior to our inspection.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. Staff were aware of when a patient may require an advocate to support them however, there was very little information about advocacy services available for patients in the waiting room or reception area.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs, mobility scooters and pushchairs. This made movement around the practice easier and helped to maintain patients' independence.

The practice provided weekly support to patients living in a local home for people with serious head injuries. Originally several GP practices supported patients there but to ensure the most effective continuity of care the practice took on the care of all the people in the home. Named GPs visited the home for half a day each week and reviewed all patients six-monthly or annually.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

Access to the service

The practice was open from 08:30 to 18:30 Monday to Friday and was closed between 13:00 and 14:00. The practice also offered appointments up until 7:30 pm one evening a week. These surgeries were for pre-booked appointments only. These were mostly on a Tuesday evening to coincide with the evening Stop Smoking clinic

Good

Are services responsive to people's needs?

(for example, to feedback?)

but once a month (usually on the first week of the month), the practice ran a late surgery on a Wednesday evening. Patients were required to book an appointment or ask Reception about online booking for these appointments.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions where these were identified as necessary. These also included appointments with a named GP or nurse. Home visits were made to eight local care homes, by a named GP and to those patients who needed one. One of the homes was visited on a specific day each week by the named GP.

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

- 87% were satisfied with the practice's opening hours compared to the CCG average of 78% and national average of 76%.
- 97% described their experience of making an appointment as good compared to the CCG average of 80% and national average of 74%.
- 88% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70% and national average of 65%.
- 87% said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 72%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice.

Routine appointments were available for booking six weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had usually been able to make appointments on the same day of contacting the practice.

Home visits were available for older people and people with long-term conditions where needed and longer appointments were also available as required by individuals. Appointments were available outside of school hours for children and young people and the premises were suitable for children and young people. An online booking system was available and easy to use, telephone consultations where appropriate were also available. The practice supported patients to return to work through referrals to other services such as physiotherapists or counsellors as well as by providing 'Fit Notes' in support of a phased return to work.

We saw partnership working for patients whose circumstances may make them vulnerable to help staff understand the needs of the most vulnerable in the practice population. Longer appointments were available for those that need them and staff avoided booking appointments at busy times for people who may find this stressful.

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 in the practice leaflet and on their website to help patients understand the complaints system. About half the 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 six complaints received in the last 15 months and found these were satisfactorily handled and had been dealt with in a timely way. The practice had a policy of openness and transparency when dealing with the complaints and kept patients informed of what they were doing in response to the complaint made. We saw the practice told the patient about the outcome of their investigations and apologised to patients in writing where this was appropriate.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. We saw minutes of team meetings which showed that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

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 current business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included; providing good quality primary care services delivered in a clean; suitably equipped and safe environment; making efficient use of NHS resources whilst providing clinically appropriate access to other NHS services such as consultant referrals, diagnostic tests and effective treatment and involving patients in the development and maintenance of good quality services through the patient participation group and patient feedback.

We spoke with a range of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the practice away day held on 16 October 2014 and saw that staff had discussed and agreed that the vision and values were still current.

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 12 of these policies and procedures and all 12 policies and procedures we looked at had been reviewed, amended and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a member of staff with lead responsibility for infection control and the registered manager/partner was the lead for safeguarding. 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 manager and GP partners took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. These included using the Somerset Practice Quality Scheme (SPQS) and Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The SPQS and QOF data for this practice showed it was performing in line with national standards. We saw that SPQS, prescribing data and QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, in reducing prescribing rates for analgesic medicines. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the Clinical Commissioning Group.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example, improving hygiene standards and the environment in the waiting room and treatment rooms. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff and clinical meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, disciplinary procedures, induction policy, management of sickness which were in place to support staff. We were shown the recently revised staff handbook that was available to all staff, which included sections on equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Are services well-led?

Good

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were always approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice. The partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held every month. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held annually. Staff said they felt respected, valued and supported, particularly by the partners in the practice. They also told us about social events organised by the practice which they attended.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups including those recently retired and those with long term conditions. The PPG had carried out surveys and met every two months. 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 are available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. For example, they told us about their involvement in producing a new practice patient information leaflet. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff away days and generally 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 staff told us that they had asked for specific training around phlebotomy at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended. For example, the health care assistant told us about how they were supported to develop in their role by being provided with access to training and support through the practice. They had gained an NVQ3 in Health Care and were hoping to be supported to commence an Open University degree in nursing in the near future.

The practice was a GP training practice serving the Severn Deanery. The practice supported medical students and foundation doctors. We spoke with a registrar GP and an F2 medical student during our inspection; both were very complimentary about the support they received from the practice and their GP supervisors.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, more effective procedures for handling power failures, improved patient checks to ensure the correct patient is identified and safer prescribing for patients requiring weekly repeat prescriptions.