Clevedon Medical Centre

Quality Report

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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

The Green Practice and Clevedon Riverside Group merged in April 2015 to form the Clevedon Medical Centre. We carried out an announced comprehensive inspection at Clevedon Medical Centre on 1 September 2016.

Overall the practice is rated as good.

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

- The leadership, governance and culture were used to drive and improve the

delivery of high-quality person-centred care.

- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, the area had a high number of older people and the practice employedan Elderly Care Nurse who managed the patients living in care homes, providing proactive care and advice regarding patients and education to the staff in the homes.
- Feedback from patients about their care was consistently positive. Patients told us that the care that they received exceeded their expectations.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they met patients' needs. For example they worked closely with the nearby nurse led minor injuries unit and were able to see children and young people when requested.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example they used an audible tannoy for calling patients to appointments and as a result of feedback from patients, were introducing an electronic visual call system.

Summary of findings

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice had introduced a new clinical team for urgent care in 2016 to improve accessibility to a clinician. The team comprised Advance Nurse Practitioners, a Physician Associate, Nurse Prescribers, a Practice Pharmacist and an Acute Care Practitioner. This provided additional same day appointment capacity for minor illness appointments. Feedback from the patient participation group members was positive and they told us that they were able to get appointments when they needed them.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw some areas of outstanding practice:

- The targeted assessment protocol for the areas of increased health risk in patients diagnosed with Down's syndrome was in line with best practice and addressed the needs of a vulnerable minority group. We saw findings were used by the practice to improve services. For example, they had identified specific risks for these patients and additional measurements and checks were included in the Learning Disability annual review.
- The practice ran a free half-day course annually for North Somerset sixth form pupils who were interested in a career in medicine. The course was called 'Widening Access to Medicine' and had run for seven years with an average of 15 students per year. The course content had also been shared with the Royal College of General Practitioners and another local practice as a way to support future recruitment into primary care.

The areas where the provider should make improvement are:

- The practice should proactively demonstrate that they can prove that and that patients are happier with phone access and opening hours. Patients need to feel that they have made an improvement.

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.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risk management was comprehensive, well embedded and recognised as the responsibility of all staff.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was delivered in a coordinated way.

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed 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.

Summary of findings

- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- Practice staff reviewed the needs of its local population and engaged with the NHS England area team and clinical commissioning group to secure improvements to services where these were identified. For example, the practice was part of a pilot project for providing hub appointments for patients on weekends.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions, including people with a condition other than cancer and people with dementia.
- Patients said they found it easy to make an appointment with a named GP and 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 the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.
- The practice had reviewed their staffing establishment and had employed a wide range of health care professionals to meet demands for services. This included nurse practitioners, a clinical pharmacist, a physician associate and a primary care paramedic.
- The practice jointly employed an Elderly Care Nurse who managed the patients living in nursing and residential homes. They were involved in chronic disease management of this group of patients providing proactive care and advice regarding patients and education to the staff in the homes.

Are services well-led?

Good

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

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.

Summary of findings

- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The provider was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group was active.
- There was a strong focus on continuous learning and improvement at all levels. Staff training was a priority and was built into staff rotas.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

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.

- Staff were able to recognise the signs of abuse in older people and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older people who may be approaching the end of life. It involved older people in planning and making decisions about their care, including their end of life care.
- The practice had signed up to the Unplanned Admissions Local Enhanced Service and had identified the 2% of patients at higher risk of admission to hospital. Many of these patients are over 75 years old and were followed on their discharge from hospital which ensured that their care plans were updated to reflect any extra needs. Any unplanned admissions to hostpial were discussed at a monthly meeting with the community team.
- Where older patients had complex needs, the practice shared summary care records with local care services such as the community nurse team.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible as the practice offered patient education sessions.
- The two GP practices in Clevedon had jointly employed an Elderly Care Nurse who managed the patients living in nursing and residential homes. They were involved in chronic disease management of this group of patients and provided proactive care and advice regarding patients as well as providing education to the staff in the homes. All patients were visited annually as a minimum for an assessment of their needs, medicine reviews and chronic disease management. The GPs in both practices supported the nurse in clinical matters on a daily basis, and they had a two monthly meeting with the Elderly Care Nurse to plan the clinical services for patients. For example, they had introduced standby antibiotics for patients with an agreed protocol as to when these were to be used for example, for those who had frequent infections.

Summary of findings

- The two local practices were working towards agreed overall responsibility for the local care and nursing homes between them to be more proactive in the management of patients in these homes. This model had already been successfully implemented by the practices in a residential home for patients living with dementia where there was a nominated GP who visited twice weekly to do a ward round. Communication between the practice and the home was by telephone or email.
- The practice worked to the Gold Standards palliative care framework and were able to access 24 hour advice from the local hospice.

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 long-term disease management and patients at risk of hospital admission were identified as a priority.
- The practice proactively identified patients at risk of developing long-term conditions and took action to monitor their health and help them improve their lifestyle. For example, patients with long term conditions were given self-care programs. Information leaflets were advertised in numerous locations around the building, on the website, in the patient newsletter, and by the practice nurses in the chronic disease clinics. Patients attending the clinics were routinely screened for anxiety and depression so that they could be supported appropriately.
- The practice was participating in the 3D Study which looked at the GP management of care for patients with three or more long term health conditions. The aim was to treat the whole patient in a consistent, joined up manner in order to improve their overall quality of life.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health such as 'just in case' medicines.
- Longer appointments and home visits were available when needed.

Summary of findings

- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.
- The practice proactively identified those patients at risk of developing a long term condition by offering specific health check appointments with the practice nurses. GPs also had an "open access" policy whereby examination, blood tests; BP checks were performed if requested by a patient.
- The practice had a register of the 2% of patients with the most complex needs. Each patient had a care plan tailored to their individual needs, completed by a GP following a face-to-face meeting with them. The care plan was regularly reviewed. Each patient was assigned an appropriate care coordinator. The practice had a special designated telephone line only available to this 2% of patients and their carers.
- The practice offered a home visit service; patients with non-urgent issues were usually seen at lunchtime. Urgent visit requests were dealt with by a designated Duty Doctor and were prioritised during the day so that urgent visits were attended to as soon as was possible.

Families, children and young people

Good

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

- There were systems 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 accident and emergency (A&E) attendances. A+E attendances as well as clinic 'did not attend' (DNA) were coded on the child's notes and reviewed or actioned by a doctor.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses. Joint six weekly baby and postnatal check were provided for the convenience of new parents and to maximise contact with new born babies.
- The practice offered a wide variety of appointment types to cater for this patient group. These included advanced booking of appointments with options of early morning and late evening and book on the day and minor illness surgery

Summary of findings

appointments.Children under the age of five were seen as a priority in daily surgeries. They had a user friendly website allowing parents and young people to access medical and practice information.
- The practice offered an annual session for local school children exploring the option of a medical career.
- A confidential 'No Worries' sexual health service operated from the medical centre on a weekly basis for 15-24 year old patients.

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 participated in the pilot e-consultations service for all patients.

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 and those with a learning disability. They offered patients with learning disabilities annual health checks either in their own home or at a quieter time at the practice.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- 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.
- They offered a 'place of safety' in conjunction with the local police for vulnerable patients who may be lost or in crisis in the community, and this was advertised on the front door of the building.

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 living with dementia).

- The practice specifically considered the physical health needs of patients with poor mental health and worked closely with the community mental health teams to ensure patients attended their annual review.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- Patients at risk of developing dementia were identified and offered an assessment; all of these patients had a care plan in place with a copy being given to the patient. The practice had access to direct help from a memory team nurse or telephone advice when needed.
- The practice 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.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.
- The practice used weekly prescriptions and daily dosette systems for some patients to allow close monitoring of their medicine use and good communication with local pharmacists who raised concerns when they had them.
- There was a practice clinical lead for patients with mental health problems, including those on the Mental Health Register and those with depression, anxiety and other mental health

Summary of findings

problems. The register was reviewed on a yearly basis to ensure all eligible patients were on it. Annual reviews for patients on the register were undertaken both opportunistically and by active recall.

- They had an active monitoring system for patients who were attending the treatment room for anti-psychotic injections so that they could identify anyone who missed their regular injections.
- The practice directed patients needing psychological therapies to a local service 'Positive Steps' and encouraged self-referral in order to improve compliance. The practice used the 'Books on Prescription' scheme at the local library when patients prefer written material.

Summary of findings

What people who use the service say

The national GP patient survey results were published on July 2016. The results showed the practice were not always performing in line with local and national averages. 230 survey forms were distributed and 140 were returned. This represented 0.9% of the practice's patient list.

- 60% of patients found it easy to get through to this practice by phone compared to the clinical commissioning group average of 71% and the national average of 73%.
- 67% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the clinical commissioning group average of 76% and the national average of 76%.
- 80% of patients described the overall experience of this GP practice as good compared to the clinical commissioning group average of 87% and the national average of 85%. It should be noted that the timescale for the survey encompassed the period of time when the practice was going through their merger.
- 73% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the clinical commissioning group average of 81% and the national average of 80%.

We spoke with two patients during the inspection. Both patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

The practice undertook the NHS friends and families test and we saw from the respondents for July 2016 that 90% of patients would recommend the practice.

Clevedon Medical Centre

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 specialist adviser and a nurse specialist adviser.

Background to Clevedon Medical Centre

Clevedon Medical Centre is a practice providing primary care services to patients resident in Clevedon and the surrounding villages.

The practice operates from one location:

Old Street,

Clevedon,

North Somerset

BS21 6DG

The premises are located in a large, modern purpose-built building on a main thoroughfare just outside the main shopping precinct and opposite the local community hospital. They have patient and staff parking and designated blue badge bays in the patient car park.

There is wheelchair access through the power assisted main front door and an accessible toilet facilities are available. All public and consulting rooms are on the ground floor and easily accessible. They have a lift to provide disabled staff access to the first floor administration rooms.

The practice has a patient population of approximately 16,000. Approximately 41% of the patients are over the age of 65 years compared to a national average of 27%. Approximately 59% of patients have a long standing health condition compared to a national average of 54%.

The practice has seven GP partners (male and female), five salaried GPs ,a business manager and an operations manager, three advanced nurse practitioners, six practice nurses, a paramedic, a physician associate, a pharmacist , a health care assistant and four phlebotomists. Each GP has a lead role for the practice and nursing staff have specialist interests such as diabetes and infection control.

The practice is open Monday to Friday 8.30am - 6.30pm and is participating in a pilot to trial weekend opening on alternate Saturdays 9am – 12noon. They offered extended hours on Monday 7.30am - 8.30 am, Tuesday 7am - 8.30am and 6.30pm - 8.00pm. Appointments are available from 8:30am and emergency telephone access is available from 8am. Telephone consultations were available with clinicians for patients and these can be flexible to meet patient availability.

The practice had a Personal Medical Services contract (PMS) with NHS England to deliver primary medical services. The practice provided enhanced services which included facilitating timely diagnosis and support for patients with dementia and childhood immunisations.

The practice is a teaching practice and takes medical students from the Bristol University and trainees from the Severn deanery.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 or BrisDoc provide the out of hours GP service.

Patient Age Distribution

0-4 years old: 5.2%

5-14 years old: 10.1%

Under 18 years:17.7%

65-74 years old: 24.6%

75-84 years old: 12.5%

85+ years old: 3.8%

Patient Gender Distribution

Male patients: 48.6%

Female patients: 51.4%

Other Population Demographics

% of Patients from BME populations: 1.89%

The practice is situated within a significantly less deprived area than the England average.

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the second least deprivation decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. It is important to remember that not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas).

Patients at this practice have a higher than average life expectancy than the clinical commissioning group (CCG) and national average with men at 81 years and women at 87 years.

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. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 1 September 2016. During our visit we:

- Spoke with a range of staff, including GPs, nursing staff and administration staff and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

To get to the heart of patients' experiences of care 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 were provided for specific groups of people and what good care looked 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).

Detailed findings

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, systems for review of test results had changed and improved the safety of the system so that results were seen and responded to in a timely way.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and nurses were trained to child protection or child safeguarding level three. The practice had conducted training sessions for all staff to engage with the local domestic violence service so they had knowledge on how to refer patients. The practice had rooms available for confidential counselling sessions on an ad hoc basis. We saw domestic violence advice posters in various places around the practice and patients were able to access advice from counsellors when necessary.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local CCG pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- There was a mixed skill base of advanced nurse practitioners, nurse prescribers who had qualified as independent prescribers and could therefore prescribe medicines for specific clinical conditions. They received mentorship and support from the medical staff for this extended role.

Good

Are services safe?

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber. We saw arrangements were in place for vaccines delivery, storage and record keeping; this system had been subject of an audit to ensure it was effective. The audit identified any areas for action but also confirmed the safety of the arrangements in place.
- We reviewed four personnel files and found 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.
- There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty .
- The practice used regular locum GPs for whom they undertook appropriate checks to ensure they were suitable to be employed, for example, checking the General Medical Council register and the NHS England Performer's List.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were implemented through the root cause analysis of significant events, audits and complaints. For example, they audited cancer prevalence and the treatment of lung cancer according to NICE guidance. They had identified 70 patients were undergoing active treatment in August 2016. 38 men and 32 women covering 24 cancer types. Four patients who had been diagnosed with lung cancer. The audit identified that in each case the patients were being treated according to NICE guidelines including use of X-rays and CT scans, smoking cessation advice, if appropriate, and appropriate medicines.

Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from 2014/15 were 98.9% of the total number of points available. We saw overall exception reporting at 8% was lower than the clinical commissioning group (CCG) at 11% or national averages at 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the clinical commissioning group (CCG)and national average. For example, the percentage of patients with diabetes, on the register, in whom the last IFCC-HbA1c was 64 mol/mol or less in the preceding 12 months (01/04/2014 to 31/03/2015) was 76% compared to the clinical commissioning group average of 77% and the national average of 78%.
- Performance for mental health related indicators was similar to the CCG and national average. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (01/04/2014 to 31/03/2015) was 92% with the clinical commissioning group average of 93% and the national average of 88%.

There was evidence of quality improvement including clinical audit.

- There had been 12 clinical audits undertaken in the last years, two of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research.

We saw findings were used by the practice to improve services. For example, they undertook an audit of adults with Downs Syndrome. This audit reviewed the 16 patients on the practice list, all of whom received an annual Learning Disabilities (LD) health check which included the management and screening of their comorbidities.

The audit identified specific risks for these patients the outcome of the audit of these patients was that additional measurements and checks were included in the Learning Disability annual review such as:

- Consideration for screening for coeliac disease
- Check for symptoms of sleep apnoea
- Check for symptoms of dementia over 40
- Ensuring immunisations are up to date as highest cause of death was respiratory problems.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

Good

Are services effective?

(for example, treatment is effective)

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, we found a practice nurse had completed their prescribing course, a nurse practitioner had completed a diploma in asthma care and a treatment room nurse was supported through their Advanced Nurse Diploma and Diabetes diploma. Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. The practice provided mentorship for staff wishing to expand their clinical and non- clinical skills and offered study time and support funding where appropriate for staff wishing to undertake courses that were of benefit to the practice. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. The practice ran regular Clinical Learning Groups for the clinical staff and invited clinical speakers to both GPs and nurse meetings for education and training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services. We were told patient correspondence from other health and social care providers was scanned into patient records once the GPs had seen the results. This ensured the patient records were current and held electronically to be accessible should they be needed, for example, for a summary care record to take to the hospital. The practice is connected to the Summary Care Record nationally and Connecting Care locally which allowed out-of-hours services to access patient information.
- Community nurses teams could access a restricted area of the patient records remotely for any test results and to add details of their visits.
- Patients' blood and other test results were requested and reported electronically to prevent delays. All of the results were reviewed on the day they were sent to the practice to minimise any risks to patients so that any necessary actions was taken.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different people, including those who may be vulnerable because of their circumstances.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

Good

Are services effective?

(for example, treatment is effective)

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation. They referred patients to the local services offered for weight reduction via the North Somerset map of medicine pathways. These included psychological help, fitness passes and slimming group membership.
- A dietician was available on a fortnightly basis in the practice.
- The medical centre advertised local public health messages and social services and activities on a regular basis for example, 'Health Walks'.
- The practice also delivered patient education events in 2016, the first of which was a dementia event in the summer.

Information from the National Cancer Intelligence Network (NCIN) indicated the practice's uptake for the cervical screening programme was 77%, which was comparable to the national average of 74%.

Childhood immunisation rates for the vaccines given were comparable to the clinical commissioning group(CCG) averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 90% to 99% compared to the CCG average from 83% to 99% and five year olds from 89% to 99% compared to the CCG average from 93% to 99%.

Patients had access to appropriate health assessments and checks. These included health checks for new patients with appropriate follow-up for the outcomes of health assessments and checks where abnormalities or risk factors were identified. The practice proactively identified those patients at risk of developing long term conditions by offering specific health check appointments with the practice nurses. GPs also had an "open access" policy whereby examination, blood tests; BP checks were performed if requested by a patient.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Same sex clinicians were offered where appropriate.
- We found the building was spacious and well lit, well heated and ventilated with appropriate signage. The building had been designed to allow easy and safe access to all areas and rooms. Maintenance planning for the building now included plans to use contrasting paint colours on doors and walls to improve contrast for visually impaired patients and those living with memory loss or dementia.

Patients we spoke with told us they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with two members of the patient participation group (PPG). They also told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. They told us that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was comparable to clinical commissioning group (CCG) and national averages for its satisfaction scores on consultations with GPs and nurses. For example:

- 86% of patients said the GP was good at listening to them compared to the CCG average of 90% and the national average of 89%.
- 87% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 96% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 96% and the national average of 95%.
- 88% of patients said the last GP they spoke to was good at treating them with care and concern compared to the national average of 85%.
- 91% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the national average of 91%.
- 82% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 83% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 87% and the national average of 86%.
- 80% of patients said the last GP they saw was good at involving them in decisions about their care compared to the national average of 82%.
- 80% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

Good

Are services caring?

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available. Patients were also told about multi-lingual staff who might be able to support them.
- Information leaflets were available in easy read format.

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Patients at the practice had access to a local voluntary group who will transport patients to and from appointments.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 326 patients (2%) as carers. Written information was available to direct carers to the various avenues of support available to them. Elderly carers were offered timely and appropriate support. All carers were offered a health check .

The practice had prepared a leaflet for patients which provided information and signposting of services they may need. On notification of a death, GPs called the family to offer condolence and support, and a sympathy card was sent. Patients may access GP appointments to support them through the process and some may be referred to local bereavement services if desirable.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.

- There were longer appointments available for patients with a learning disability. The practice offered patients with learning disabilities an annual health check either in their place of residence, or at quieter times at the practice.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that required same day consultation. The practice offered a wide variety of appointment types to cater for this patient group. Children under the age of five were seen as a priority in daily surgeries. They had a user friendly website allowing parents and young people to access medical and practice information.
- We saw positive examples of joint working with midwives, health visitors and school nurses. Joint six weekly baby and postnatal check are provided for the convenience of new parents and to maximise contact with new born babies.
- The practice offered a confidential sexual health service with a weekly evening nurse-led No Worries Clinic.
- The practice had signed up to the Unplanned Admissions local enhanced service and had identified the 2% of patients at higher risk of admission to hospital. Many of these patients were over 75 years old and were followed up on discharge from hospital; any unplanned admissions were discussed at a monthly meeting with the community team.
- The practice had a register of the 2% of patients with the most complex needs. Each patient had a care plan tailored to their individual needs, completed by a GP following a face-to-face meeting with them. Each patient was assigned an appropriate care coordinator. The practice had a special designated telephone line only available to these 2% of patients and their carers.
- The practice worked to the Gold Standards palliative care framework and was able to access 24 hour advice from the local hospice.
- Patients were able to receive travel vaccines available through the NHS.
- There were accessible facilities and designated parking bays for blue badge holders. Other reasonable adjustments were made and action was taken to remove barriers when patients find it hard to use or access services.
- The building was spacious and well lit, well heated and ventilated with appropriate signage. The building has been designed to allow easy and safe access to all areas and rooms. Maintenance planning for the building now included plans to use contrasting paint colours on doors and walls to improve contrast for visually impaired patients.
- There was a practice clinical lead for patients with mental health problems, including those on the Mental Health Register and those with depression, anxiety and other mental health problems. They had an active monitoring system for patients who were attending for anti-psychotic injections so that they could identify anyone who missed their regular injections. The practice used weekly prescriptions and daily dosette systems for some patients to allow close monitoring of their medicine use.
- Patients at risk of dementia were identified and offered an assessment; all of these patients had a care plan in place with a copy was given to the patient. The practice had access to direct help from a memory team nurse or telephone advice when needed. They carried out advance care planning for patients with dementia.
- The practice offered a 'place of safety' in conjunction with Avon and Somerset police, for vulnerable patients who may be lost or in crisis in the community, and this was advertised on the front door of the building.
- The practice directed patients needing psychological therapies to Positive Steps and encouraged self-referral in order to improve compliance. The practice used the 'Books on Prescription' scheme at the local library when patients prefered written material.
- The practice proactively identified patients at risk of developing long-term conditions and took action to monitor their health and help them improve their

Good

Are services responsive to people's needs?

(for example, to feedback?)

lifestyle. For example, patients with long term conditions were given self-care programmes and information leaflets were advertised around the building, on the website, in the patient newsletter, and by the practice nurses in the chronic disease clinics. Patients attending the clinics were routinely screened for anxiety and depression.

- The practice had invited patients living with dementia to come to the practice for a memory clinic event.Patients and their carers were given an opportunity to meet with others in similar circumstance as well as representatives from some of the local support agencies in a non-clinical environment with afternoon tea.As part of their training the trainee GPs met with each patient on an individual basis during the afternoon to review their dementia care plan.
- The practice also worked collaboratively to provide medical care to the local community hospital and minor injuries unit. The service involved booking in new patients for rehabilitation, daily ward rounds and a weekly consultant led ward round. There were two named GPs who provided this service in conjunction with the other GP practice in the area providing a continuity of care for patients.
- The practice worked collaboratively to provide a specialist elderly care nursing service to patients in local nursing and residential care homes (approx. 400 patients locally). The two GP practices in Clevedon jointly employed an elderly care nurse who managed the patients living in care homes. All patients were visited annually as a minimum for an assessment of their needs, medicines reviews and chronic disease management. They had introduced standby antibiotics for patients with an agreed protocol as to when these are to be used.
- The practice had reviewed their staff establishment and had employed a wide range of health care professionals to meet demands for services. This included nurse practitioners, a clinical pharmacist, a physician associate and a primary care paramedic.
- The practice had committed to providing practice nurse support for a local Leg Club (Leg Clubs are an evidence based initiative which provide community-based treatment, health promotion, education and ongoing care for people of all age groups who are experiencing leg-related problems. Leg Club staff work in a unique partnership with patients (members) and the local community. They provide care in a social and friendly setting that promotes understanding, peer support and informed choice.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday taking telephone queries from 8am. Extended hours were available on Monday 7.30am - 8.30 am and Tuesday 7am - 8.30am and 6.30pm - 8.00pm.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them. Appointments were accessible to all patients and include GP, nurse and health care assistant appointments. This was a pilot service which will run until March 2017.

Results from the national GP patient survey published in July 2016 indicated patient's satisfaction with how they could access care and treatment was lower than local and national averages.

- 71% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group average of 81% and the national average of 79%. The period of time covered by the survey included the period of time when the two practices were merging. From July 2016, additional appointment capacity was available on Saturday mornings between 9am -12 noon.
- 60% of patients said they could get through easily to the practice by phone compared to the clinical commissioning group average of 71% and the national average of 73%.
- The practice participated in the pilot e-consultations service for all patients.

The practice staff had recognised patients satisfaction in regard to access was below the expected local and national averages. In order to improve patient accessibility the practice undertook an audit of frequent attenders. The aim of the audit was to establish the list of patients interacting with GPs or nurse practitioners for face to face telephone consultations more than eight times in the previous 12 months. This was then compared with the list of patients who had been identified as at risk of unplanned admissions and who had current unplanned admission care plans. Once identified, the clinicians were asked to draw up a management plan for the patient. The audit

Good

Are services responsive to people's needs?

(for example, to feedback?)

identified 272 patients who had high levels of interaction (up to 45 interactions per year). The practice had planned to review this to identify new patients and to evaluate if management plans had proved to be effective so any learning could be shared.

The practice had introduced a new clinical team for urgent care in 2016 to improve accessibility to a clinician. The team comprised of Advance Nurse Practitioners, a Physician Associate, Nurse Prescribers, a Practice Pharmacist and an Acute Care Practitioner. This team now see virtually all patients presenting with new acute illnesses, releasing GPs to concentrate on complex and ongoing medical conditions. Members of the team also carried out some of the home visits and undertook patient medicines reviews. This provided additional same day appointment capacity for minor illness appointments. Feedback from the patient participation group members was positive and they told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

This was carried out by telephone triage when patients first contacted the practice, the administration staff had a process of assessing each patients need and sought advice from the duty clinician. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. The practice policy was that the patient was visited by the same GP where possible to provide continuity of care. They had recruited a paramedic to participate in the home visiting service, particularly for patients with acute care needs.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- Its complaint 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 complaint system on the website and a practice leaflet.
- All complaints were categorised in order to identify any trends.

We looked at a selection of the 25 complaints received in the last 12 months and found these were dealt with in a timely way to achieve a satisfactory outcome for the complainant. For example, complaints were responded to by the most appropriate person in the practice and wherever possible by face to face or telephone contact. The information from the practice indicated at what stage the complaint was in its resolution.

All complaints were categorised and analysed for trends. Lessons were learnt from concerns and complaints and action was taken as a result to improve the quality of care. We found the learning points from each complaint had been recorded and communicated to the team or appropriate action taken. For example, where there had been a number of complaints about staff attitude, additional training had been provided. Another example we saw concerned errors on a patient's repeat prescription where the solution proposed for this was that this patient's repeat requests were sent directly to the practice manager (envelope provided) to enable them to ensure the current medicines were requested. We also saw that concerns recorded about appointment access on the NHS Choices website were responded to and people were invited to attend the practice to discuss their experience.

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.

The mission statement was:

"Our Practice aims to plan for and provide the highest standard of primary care for our patients with an appropriately trained, approachable, and mutually supportive practice team.

Our business will be forward thinking, efficient and well run, and will be committed to training and research within the NHS.

The practice had a strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The leadership, governance and culture are used to drive and improve the delivery of high-quality person-centred care.

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. All of the partners undertook responsibility in different areas of practice such as vaccines or mental health and reported back at meetings.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- There was a formal schedule of meetings to plan and review the running of the practice, for example, the GPs and practice manager met weekly for business planning.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. For example, they monitored data on unplanned admissions to hospital as part of their involvement with the local clinical commissioning group (CCG).

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment.

- The practice gave affected people reasonable support, truthful information and a verbal and written apology
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Are services well-led?

Good

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

- Although the nursing team were relatively new in post, we observed strong leadership within the nursing team with examples of support for clinical work and professional development; monitoring and allocation of workload and delegation of tasks appropriate to level of skill. We saw the team had regular, minuted meetings which promoted information sharing and team involvement.

The practice had a strong culture of collaboration and partnership working with other practices. They had been able to develop research activity in the practices with numerous studies actively recruiting in the practices and provide a peer support network.

Seeking and acting on feedback from patients, the public and staff

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice used an audible tannoy for calling patients to appointments and as a result of feedback from patients, were introducing an electronic visual call system.
- The practice were actively engaged with the patients directly through a series of surveys and direct contact. For example, we were told about the public meetings organised and held by the practice to inform patients about the merger of the practices. Patients who attended the meetings told us they found them informative and a respectful way of introducing major changes to the way their service was provided. The practice had undertaken four patient surveys to evaluate how the services provided were perceived and used by patients. These were on-line booking of appointments (August –November 2015) as the uptake of on-line booking of appointments was very low; e-consultations (March-May 2016) to evaluate the use of E-consultations; extended hours appointments (January- February 2016); available services survey (June – August 2106) following on from the previous surveys the practice conducted a survey to identify which services patients were aware of and accessed.
- The practice had gathered feedback from staff through staff meetings, appraisals and discussion. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. For example, when the two practices were planning to merge staff were involved in a series of meeting to prepare them for the change. There was a nominated staff member from each work team who attended work planning meetings and gave feedback to the staff and management team about proposals and suggestions to make the merger successful. Staff who spoke with us about this were very positive about their involvement and the sense of ownership of the change it provided. Staff told us they felt involved and engaged to improve how the practice was run.
- The practice used social media to inform those patients who may not use GP services frequently about upcoming events.
- The practice had a suggestion box and ran the family and friends test.
- The practice updated patients with a regular newsletter and a news section on the website.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. A systematic approach is taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money.The practice were part of the One Care Consortium (an integrated approach to the delivery of primary care across GP practices in Bristol, North Somerset and South Gloucestershire), a member of their management team was an executive committee member. As a Wave 1 practice they were involved in the development and transformation of primary care services and seven day working. There is strong collaboration and support across all staff and a common focus on improving quality of care and people's experiences.

The practice participated in the following pilots:

Are services well-led?

Good

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

- A Physiotherapy pilot where patients had direct access to a physiotherapist instead of a GP for any new musculoskeletal problems.
- Telephony pilot working toward a centralised call handling resource.
- Call handling training which was a pilot to standardise training for calls coming into the practice.
- Remote working testing the usability of tablets for clinicians visiting patients in the community.

The practice also developed their service in the following ways:

- The practice ran a free half-day course annually for North Somerset sixth form pupils who were interested in a career in medicine. The course was called 'Widening Access to Medicine' and had run for seven years with an average of 15 students per year. The course content had also been shared with the Royal College of General Practitioners and another local practice as a way to support future recruitment into primary care.
- The practice supported GP & nurse training. They had three GP trainers with 3-4 trainee GPs undertaking training at any one time. From October 2016 they will be hosting and mentoring student nurses. They also had 5th year medical students.
- The practice participated in an apprenticeship scheme to provide opportunities for young people from North Somerset to develop a career in primary care.
- The practice participated in research through the Primary Care Research Network (PCRN) and the National Institute for Health Research (NIHR). One current project was the 3D Study which looked at the GP management of care for patients with three or more long term health conditions. The aim was to treat the patient holistically rather than by disease type in order to improve their overall quality of life.
- One GP had been actively involved with the RCGP as a clinical research lead in the field of care of patients with a learning disability . They researched and developed the clinical template for health checks and shared this locally and nationally, supporting health care professionals with advice and guidance. The practice also ensured GP trainees and nurse trainees had an opportunity to participate in these health checks to raise their awareness of treating patients with a learning disability.
- The practice was part of West of England Academic Health Sciences Network "Don't wait to anticoagulate project", and dedicated GP and Practice Manager time over a 6-12 months period to join a project team engaged in the development of protocols and toolkits for clinicians and patients, to support patients in their decision making of treatment choices for anticoagulation. This included the recently changed NICE guidance and aimed to reduce the number of strokes in the population. The project was a pilot, in advance of rolling out the resources to over 200 practices in the west and south west.