Cranleigh Gardens Medical Centre

Quality Report

Cranleigh Gardens, Bridgwater, Somerset, TA6 5JS

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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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out a comprehensive inspection of Cranleigh Gardens Medical Centre on 18 November 2014. The provider has a branch surgery in Westonzoyland, Somerset but we did not inspect this as part of our inspection.

Overall we judged this service as good.

Our key findings were as follows:

- Routine appointments could usually be fitted in within a week. If a patient requested they were given a same-day triage call.
- Patient's needs were assessed and care was provided accordingly.
- There were systems in place to ensure the safety of patients, staff and visitors to the practice.
- The patient participation group (PPG) actively engaged with patients to seek feedback and acted as "eyes and ears" for the practice management. Where changes were made to the operation of the practice the PPG acted as intermediary to provide patients' views.
- The practice manager and deputy manager had an open door policy and staff told us they were approachable. Staff said they could go to the practice manager, deputy, their team leader or any of the GPs for support if needed.

We saw several areas of outstanding practice including:

- For patients with long term conditions the practice had developed a 'patient passport'. The practice leaflet explained the 'passport' was a small booklet that patients took to appointments to help with the booking of follow-up appointments. The aim of the passport was to help direct the patient by recording when they needed to be seen, by whom and for what purpose. This ensured patients were seen in a timely way.
- As part of succession planning the practice was engaging with the Equality and Diversity Forum so that it would be able to meet the needs of any population group growth.

Summary of findings

- There was a men's health event provided by the practice. Men were invited to the event to enable them to gain specific information relating to men's health issues.

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

The provider should:

- The provider should ensure the start date for the use of sharps bins is recorded.
- In order to protect staff and patients GPs should not leave medicines on desks, unsecured.

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. Lesson were learned and communicated amongst the staff team to support improvement. Risks to patients were assessed and well managed. There was safe recruitment practice and sufficient 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 the average for the locality. Staff referred to guidance from the National Institute for Health and Care Excellence (NICE) and used it and other guidance routinely. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing mental capacity and promoting good health. Staff received training appropriate to their roles and had a plan for future training devised in accordance with their annual appraisal. Staff worked in cooperation with multi-disciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services. Patients rated the practice highly for all aspects of their care. Feedback from patients was positive and they told us they were treated with compassion, dignity and respect and were involved in decisions about their care. We saw patients being treated with kindness and respect and staff maintained confidentiality. Information to help patients understand the services available was easy to understand. Views of external stakeholders was positive.

One of the senior GP partners had learned some Polish phrases to enable them to communicate more effectively with patients whose first language was Polish.

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 and Somerset Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make appointments with a named GP and there was continuity of care. Appointments were available the same day in the event of an emergency.

Summary of findings

The practice was purpose built and there was room for expansion. It 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. Evidence showed the practice responded to and learned from complaints.

Are services well-led?

Good

This practice is rated as good for being well-led. The practice had a clear vision with 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. We saw high standards within the practice and teams worked together to ensure the best service for patients.

Governance and performance management arrangements were reviewed and took account of best practice guidance. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice had an active patient participation group.

Summary of findings

What people who use the service say

We spoke with seven patients who were attending the practice for appointments on the day of our visit. They included patients of working age, older patients and mothers with their children. Patients told us they found the service they received to be good with appointments available to suit them. They spoke about the caring nature of the GPs and nurses they saw and said they would recommend the practice to others. Patients mentioned the speed of referral to secondary services, reminder letters for tests and how lifestyle was discussed during appointments.

Patients told us they were given choices regarding treatment and how their privacy and dignity was respected.

We received 21 comments cards completed by patients in advance of our visit. All of the comments cards contained positive descriptions of the care, treatment and support people received. Staff were described as polite, efficient and professional and the environment as clean, warm and comfortable.

We contacted the district nursing team. They told us the practice and its staff endeavoured to support the district nurses in caring for shared patients. They said that any issues that arose were addressed so that together they could provide safe care. They told us about the good communication with the practice and how queries were dealt with promptly and efficiently. We asked the district nurses if they thought the practice was caring and they told us that they judged this by how knowledgeable the GPs were about the complex patients they cared for at home. They added that requests for prescriptions, GP visits and information were actioned promptly. They told us they believed the staff at Cranleigh Gardens to be a strong team with good leadership.

We asked for feedback from the care homes supported by the practice. Those that responded to our request described the practice as always helpful and responsive. They told us the GPs would visit if requested and had a good bedside manner with their patients. The practice nurses were described as helpful. We were told all practice staff were pleasant caring and obliging and prescriptions were available in a timely way. One of the care homes reported the GPs were especially helpful with end of life care.

Areas for improvement

Action the service SHOULD take to improve

The provider should ensure the start date for the use of sharps bins is recorded in order to comply with the Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

In order to protect staff and patients GPs should not leave medicines on desks, unsecured.

Outstanding practice

For patients with long term conditions the practice had developed a 'patient passport'. The practice leaflet explained the 'passport' was a small booklet that patients took to appointments with them to help with the booking of follow-up appointments. The aim of the passport was to help direct the patient by recording when they needed to be seen, by whom and for what purpose.

The practice manager met regularly with the partners in the practice to discuss the development of the service.

There was a men's health event provided by the practice.

Cranleigh Gardens 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 and the CQC Head of Primary Care and Integrated Health for the South Region.

Background to Cranleigh Gardens Medical Centre

Cranleigh Gardens Medical Centre, Cranleigh Gardens, Bridgwater, Somerset, TA6 5JS is a purpose built facility set over two floors. It opened in February 2011 having formerly been based at the Brent House Surgery. The practice currently has all consulting and treatment rooms on the ground floor with offices and staff facilities on the first floor. There are some rooms on the first floor made available for visiting therapists and counselling. Part of the upper floor is leased to another service provider temporarily so that it could be used in the future for expansion of the practice.

There are four partner GPs, three male and one female, a female salaried GP and two GP registrars. The practice employs eight nursing staff including, healthcare assistants. The practice manager was supported by a deputy manager, five administrative staff and a team of nine receptionists.

The practice was a training practice for GPs and medical students and one of the GP partners was a specialist dermatologist.

The practice held a contract with Somerset Primary Healthcare Limited (clinical commissioning group) to provide enhanced medical services. Enhanced services are those that are above the standard primary medical services contract.

Since 2006 the practice list of registered patients had increased from 7,500 to almost 9,200 and had nearly an even split of male and female patients. Information obtained from Public Health England showed the practice population had a higher than the national average for the percentage of patients with long-standing health conditions, patients who were also carers and unemployed patients.

The practice had a branch surgery in Cheer Lane, Westonzoyland, Somerset TA7 0EY.

The practice contracted out of hours services with the NHS 111Out of Hours GP Service.

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

Detailed findings

Why we carried out this inspection

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

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

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

How we carried out this inspection

We consulted with the NHS England Local Area Team and Somerset Clinical Commissioning Group in advance of our inspection. They had no concerns relating to Cranleigh Gardens Medical Practice. We also met with the Somerset Local Medical Committee and shared information with the GP practice managers about our processes. We also met with Healthwatch Somerset.

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 patient's needs?
- Is it well-led?

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 November 2014. During our visit we spoke with a range of staff including the four partner GPs, one salaried GP, registrar GP and practice manager. We also spoke with the practice manager's deputy and personal assistant, medical secretary four reception staff and four administrators. We spoke with seven patients who used the service. We reviewed 21 comment cards where members of the public shared their views and experiences of the service. We also contacted local care homes that were supported by the practice and the district nursing team.

Good

Are services safe?

Our findings

Safe track record

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

One of the GPs told us how the practice developed templates to use within its computer records system. These included checklists for specific conditions and were based on latest guidelines including those issued by the National Institute for Health and Care Excellence (NICE).

The practice used patient safety alerts to audit clinical issues to ensure they were in line with current good practice guidance.

Learning and improvement from safety incidents

We saw the significant events log. There was a summary of the event along with discussion, analysis and conclusion. Where other services were involved they were made aware of significant events to prevent recurrence.

Alternate weekly clinical meeting were used to review significant events analysis and consider any new NICE guidelines.

We looked at the report of actions taken in respect of a significant event. It was the subject of a complaint that was escalated to the health services ombudsman. The complaint was partially upheld although elements of good patient care were acknowledged. The practice responded by devising a template to prompt and record activity to provide best care and good documentation.

Reliable safety systems and processes including safeguarding

The practice 'lead' for child protection was trained to level three in child protection and was also responsible for safeguarding vulnerable adults. We saw the practice policy relating to this gave a definition of vulnerable adults and described forms of abuse and indications abuse may be taking place.

The safeguarding vulnerable adult's policy showed staff what action they should take in the event of domestic abuse.

One of the GPs told us about the in-house training in safeguarding children and vulnerable patients and staff confirmed they had completed the training. Staff told us the policies and procedures were readily available and they would report any concerns to the GP lead for child protection and safeguarding vulnerable patients.

Staff said they would report concerns to one of the other GPs if the lead was not available. A member of staff told us if they noticed anything of concern prior to a child or vulnerable patient having their appointment they would alert the GP they were going to see.

One of the GPs we spoke told us they spoke with young patients about issues relating to the prescription of contraceptive medicines. They said they asked the young person about their relationship. If the child was not in a relationship, they would consider whether the child could be being exploited and consider whether to make a referral to the relevant authorities. The GP had the contact details to make child protection and safeguarding vulnerable adults referrals.

There were monthly meetings to discuss children and vulnerable patients on the practice register. These meetings included district nursing staff and health visitors to ensure their needs were met in the community.

We saw the practice whistle-blowing policy. Staff told us they would not hesitate to whistle blow if they had concerns about a colleague's performance. Some said they would speak with the member of staff in the first instance and would whistle blow depending on their response. Staff told us they were confident any concerns raised would be addressed.

All patients were entitled to have a chaperone for their protection, if they wished. A chaperone is someone who acts to protect staff and patients and assist patients to make an informed choice about their examinations and consultations. The practice chaperone policy included guidelines for staff to follow, identified who could act as chaperone and the procedure to be followed. The policy highlighted that the chaperone should make a record in the patients notes after examination to record if there were no problems or, whether there were any concerns, or if incidents occurred. The policy outlined what training for chaperones would cover. One of the GPs told us they preferred to have a chaperone present when administering hip injections. They said they used a chaperone for all

breast and gynaecological examinations. We spoke with a member of staff who described the role of chaperone. They told us they stood by the consulting room door while the examination took place and recorded in the patients notes they had been present. Staff who acted as chaperone had a criminal records check with the Disclosure and Barring Service.

Medicines management

We found good systems in place for the management of prescriptions. Repeat prescriptions could be ordered in person, by telephone, in writing or on-line. The practice would send a prescription by post if requested and a stamped addressed envelope was included with the request. There was a dedicated telephone number to call for repeat prescriptions that avoided blocking the main practice number. One of the GPs we spoke with felt the dedicated prescribing telephone line was effective and a safer way for older patients to order repeat prescriptions. The practice provided medicines in monitored dosage packs (medicines dispensing system) for frail older patients.

To help reduce wastage in the prescribing of medicines the practice followed 28 day prescribing for most patients. The practice leaflet explained this was so that more of NHS funding could be spent to improve health care. Cranleigh Gardens Medical Centre was one of the GP practices that formed the Bridgwater Bay Federation. The winter issue of the Federation newsletter included information relating to medicines available without prescription. The newsletter requested that patients helped reduce NHS costs by buying available medicines 'over the counter'.

We looked at the repeat prescribing arrangement for medicines. The person responsible for generating repeat prescriptions told us they could print a prescription if patients wanted medicines they had within the last six months. If the patient wanted medicines they had stopped they said they would make a note for the patient's GP. Prescriptions awaiting checking and signing by a GP were locked away. Prescriptions requested by letter were dealt with by a GP. Staff told us repeat prescribing was only available for patients whose condition was stable. Some patients were prescribed medicines in such a way they were dispensed monthly by the pharmacy of their choice, without the need to contact the practice again until a review was due.

The practice reviewed patient's medicines. If a test was needed as part of the medicines review a note would be attached to their prescription advising the patient which type of test they should book in for. These included re-calls for screening for cervical cancer screening to increase the number of patients having the test regularly.

One of the GPs had a supply of medicines on their desk for no reason and could not explain why they were there when we asked them about the medicines. In order to protect staff and patients medicines should not be left unsecured.

Prescribing alerts such as those from the Medical and Healthcare Products Regulatory Agency (MHRA) and National Institute for Health and Care Excellence (NICE) were received electronically. They were considered by one of the GPs and decisions about whether the practice should alter the prescribing of a medicine was cascaded to the other GPs. Alerts from the MHRA and NICE were discussed at clinical meetings. The practice conducted an annual prescribing review. There were no major issues identified in the last review.

The practice had an automatic external defibrillator and medicines for use in the event of an emergency. All of the emergency medicines were in date and were checked regularly.

Cleanliness and infection control

There were suitable arrangements to ensure the practice was clean and the risk of infection minimised. All areas of the practice were visibly clean. The practice had a contract with an external cleaning company who audited its arrangements.

We looked at the practice control of infection policy. It listed the proposals for the management of infection risk and identified the staff with responsibilities for various aspects infection control.

There was a dedicated lead person for infection control who had recently updated their knowledge by attending a three day 'refresher' course. They conducted an annual audit of infection control arrangements and we saw they had booked the next audit to be carried out on 25 November 2014.

The control of infection policy described precautions that applied in the practice as general cleaning, training, hand washing and the wearing of personal protective clothing

and equipment and basic hygiene requirements. In addition the policy outlined the arrangements for clinical waste disposal and the arrangements for the disposal of sharp instruments, such as syringe needles.

We discussed the procedure to be followed in the event of a member of staff receiving a sharp instrument injury with the nurse who led on infection control. They described how any wound would be washed until bleeding was stopped. They told us how they would contact the occupational health service for advice. We discussed the correct assembly of sharps bins and noticed they did not record the date they were put into use in line with The Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

The infection control lead told us about the two day training they completed with the Royal College of Nursing. They also told us the staff were encouraged to have vaccination against the flu virus.

There was guidance for staff in relation to the safe handling of specimens and what to do in the event of blood or other bodily fluid spillage. The practice had spillage cleaning kits that were kept centrally, in the reception area.

There was a cleaning schedule for each of the treatment rooms, examination couches had wipe clean surfaces and paper was used to cover them when in use. Curtains around the couches were disposable. All equipment was for single use and personal protective clothing and equipment was available for staff to use. We saw a good supply of soap and paper hand towels along with hand washing guidance at sinks throughout the practice.

Equipment

We saw service reports for the annual service of equipment including the fridge used for the storage of immunisations, ear syringing equipment, blood pressure monitors and the automatic external defibrillator.

Electrical equipment was tested in line with the requirements for portable appliance testing in line with the Electricity at Work Regulations 1989.

Liquid nitrogen used for the removal of warts was stored along with the operating guide in an unused part of the building for safety.

Staffing and recruitment

The practice aimed to provide the best possible care to patients and recognised in order to do so the best staff needed to be recruited. The recruitment policy stated the recruitment process should be “fair and transparent” to ensure equal opportunities were afforded candidates for employment. The policy identified the practice manager as the responsible person for recruitment and outlined the process to be followed.

We looked at the recruitment records for three staff. They showed staff had been recruited following standard recruitment processes including the taking up of two written references, verification of identity and criminal records check with the Disclosure and Barring service (DBS).

A record of interview responses was kept and new staff were subject to a probationary period of six months. We saw the staff member’s performance had been reviewed at the three month and six month stage of the probationary period before a contract of employment was issued.

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. The practice policy designated certain staff for responsibilities in respect of health and safety. The policy outlined the responsibility, name of the staff member and associated duties, including frequency. We saw the policy was reviewed in October 2014 when the health and safety arrangements were audited.

One of these was updating risk assessments. The risk assessments identified the hazards and who may be affected in addition to the measures in place to minimise risk. We saw they were reviewed in October 2014 and identified actions were recorded along with timescales and the name of who was responsible for ensuring the action was met.

We saw the fire safety risk assessment and the fire safety policy demonstrated a commitment to the safety of patients, staff and visitors. There was clear guidance for action to be taken in the event of fire, displayed.

The staff survey carried out in the practice in 2011 reflected patient safety and required staff to complete a ‘clinical risk self-assessment’. The practice manager told us they were planning this again for the near future to confirm a culture of patient safety existed in the practice.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. One of the GPs told us there was a time when patient access to appointments suffered because a GP left the practice and another GP was on extended leave. In order to respond to the situation the practice re-organised its staffing arrangements and allocated a duty GP for all same day appointments. The GP told us this had worked well.

All staff had training in dealing with medical emergencies. The practice had an automatic external defibrillator and medicines for use in the event of an emergency. All of the emergency medicines were in date and were checked regularly. The defibrillator was serviced regularly and the oxygen supply was in date.

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. One of the GPs told us how all same day appointments were triaged by a GP and how this increased the level of satisfaction for patients as they were either prescribed medicines or called in for a consultation. Each day one GP was on call. All patients who were housebound would automatically receive a home visit. Each day all of the GPs were allocated home visits.

Each of the GPs had special interests and booked patients with those conditions in for appointments. One of the staff told us they believed this provided a more flexible service to patients. One of the GPs held a dedicated dermatology clinic twice each week and accepted referrals from other GP practices in the area. The practice held clinics for patients with atrial fibrillation (abnormal heart rhythm) as part of an initiative across Somerset, supported by a medicines manufacturing company.

Management, monitoring and improving outcomes for people

The practice continued to work in line with the Quality and Outcomes Framework however aimed to meet some of the Somerset Practice Quality Standards, an alternative framework being used by GP practices in Somerset. The practice was one of a number of GP practices that formed the Bridgwater Bay Federation and on-going active involvement in the work of the Federation remained a priority for the practice.

The computer system used by the practice enabled efficient monitoring of patients health. It was used to 'fast track' from the patient's appointment to the medical secretary to make referrals for secondary care and used to prompt the GPs when actions were needed such as, re-calls for tests.

Staff were trained to respond to key words such as 'chest pain' and 'testicular pain' and would interrupt a GP if a patient mentioned these when making an appointment. The practice approach was to accept interruptions when the reception staff or nurses were worried about a patient.

Patients with long term conditions who were overdue for an annual check were called in by letter and sometimes there was a message attached to repeat prescriptions.

The practice aimed to ensure patients were given test results in advance of consultation with a GP to enable more effective discussion about treatment planning.

The GPs had a buddy system for covering hospital discharge letters so the practice could communicate with patients at the earliest opportunity if they needed to. If this is the case one of the reception staff will make contact with the patient and ask them in for an appointment within a specified time.

Any contact slips from the out of hour's service were dealt with first thing in the morning to arrange follow up appointments or visits.

One of the nurses told us how there was 'pathway tracking' for patients with complex medical conditions to enable their health to be monitored. One of the nurses we spoke with told us how if they knew they were going to be absent from work they would ensure their colleagues knew about patients with complex medical conditions. Another nurse told us how they were beginning to build up a 'caseload' of patients they saw regularly for tests and dressings. They said this provided continuity and was beneficial to patients

The practice did not run specific clinics for patients with long term conditions, other than for patients with diabetes, so they could be seen at any available time which was more effective. One of the nurses told us about the training they completed in relation to asthma and chronic obstructive pulmonary disease and how they belonged to a 'respiratory network' in order to keep up to date with these conditions. Patients with a diagnosis of diabetes had an annual health check. The practice encouraged patients with long term conditions to see the same GP for continuity.

The practice held a register of patients with learning disabilities. The practice allowed extra time in appointments and for home visits to ensure effective consultation for such patients. A GP told us their experience was that patients with learning disabilities would usually attend appointments with a relative or carer and assist with communication, where necessary. Patients with learning disabilities were offered annual health checks carried out by a GP.

Good

Are services effective?

(for example, treatment is effective)

Patients with memory loss were identified on the record system. Longer appointments were made available and in some cases patients were referred to the psycho-geriatric memory service. The GPs also referred patients to lunch clubs for community based support.

A GP told us there were some travellers' sites in the area and the practice aimed to accommodate patients who were travellers. They said there were some issues regarding access but the practice tried to be more facilitative and ensure they were seen. They said this included flexibility in respect of immunisations.

Patients aged over 40 years were invited to the practice for a health check.

Two of the GPs administered joint, pain relief, injections. A GP told us this was offered after trying other medicines for pain relief. They said the injections were administered to knees, elbows and shoulder joints. On occasions they administered injections for trochanteric bursitis (hip problems) and had a leaflet to explain this to patients. The GP explained how he would advise patients of the risks and obtain verbal consent to treatment and record it.

Where young patients were prescribed contraceptive medicines for the first time, there was a follow up appointment after three months, after six months and then annually. If the prescription for contraceptive medicines was for a young patient the frequency of follow ups would be increased. The practice also directed patients to the family planning services which were available in Bridgwater and Taunton.

Some health checks were opportunistic and GPs took the time to discuss lifestyle issues with patients such as, smoking, alcohol use, family history and exercise.

Doctors in the surgery undertook minor surgical procedures in line with their registration and National Institute for Health and Care Excellence (NICE) guidance. The staff were appropriately trained and kept up to date. They also regularly carried out clinical audits on their results and use that in their learning.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We saw staff had clear duties and responsibilities within the practice. These included the summarising of new patient notes, maintaining data for the Quality and Outcomes Framework returns, arranging immunisations for children and running clinics. Some of the nurses had specialisms such as smear testing, asthma and diabetes.

The deputy practice manager held a diploma in practice management and certificate in supervisory management. The nurses held varying qualifications including occupational health and pain management in addition to their nursing qualifications. One of the nurses was in the process of taking a diploma in asthma care. One of the healthcare assistants had attained National vocational qualification (NVQ) at level 3 in healthcare and another healthcare assistant was in the process of completing this.

The staff training plan showed the aims and objectives for completing training, how and why it would be achieved and the timescale by which it would be completed. We saw some training was carried out in-house, sometimes by an external trainer. Other training was attended externally at the events organised by the Local Medical Committee (LMC) or colleges.

We saw all staff had training in the systems used within the practice, and mandatory training as recommended by the LMC. This included fire safety, manual handling, infection control, resuscitation and dealing with medical emergencies, equality and diversity, the Mental Capacity Act 2005 and information governance. Staff also had training relevant to their field of work such as diabetes, women's health and anti-coagulation, for nurses. All staff completed training in child protection and safeguarding vulnerable adults. One of the GPs told us the practice paid for them to attend learning events arranged by the Somerset GP Education Trust.

Staff told us they were supported by their colleagues and were happy to cover for sickness absence. They told us they had good access to training and support to attend external events.

One of the staff told us they had noted that more staff were recruited as the need arose.

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. There were primary care community

Good

Are services effective?

(for example, treatment is effective)

meetings involving district nursing staff, health visitors and hospice staff. These meeting focussed on the needs of vulnerable adults, children at risk and patients with palliative care needs.

The GP registrar told us they could access support from other GPs if they were in consultation with a patient. They used instant messaging and found the other GPs supportive.

We were told there was rapid access to the mental health 'crisis team' and generally good access to all mental health services. The practice had a list of who to contact within the service. The practice had telephone access to the Children and Adolescent Mental Health Service (CAMHS).

The practice hosted an orthotics clinic for patients with the need for support shoes. We saw a letter from a patient who had written in support and thanking the practice for providing a central community point for shoe fittings.

Information sharing

The practice used electronic systems to communicate with other providers. There were fully computerised links to pathology, secondary services such as hospitals and with the out of hour's service. The Westonzoyland branch was connected to the practice computer system.

The staffing arrangements enabled patients test results and letters to be summarised and scanned into patient records speedily. For example we saw a letter received the day before our visit had been seen by the relevant GP had been scanned into the patient's record and summarised into the notes on the day of our visit.

The practice leaflet explained how the practice held a 'summary care record' for each patient. It informed patients that a simple summary detailing any allergies, unexpected reactions to medicines and recently issued prescriptions was held centrally. This enabled any healthcare profession to access the information. The leaflet explained how patients would be asked to give consent to the healthcare professional to enable them to access the summary care record.

Consent to care and treatment

The practice had a policy in line with the Mental Capacity Act (2005). It explained the lack of capacity could be due to poor mental health, severe learning disability, brain injury, stroke, unconsciousness or sudden accident and could be either temporary or permanent. The policy outlined the principles of the Act and made reference to record keeping requirements. It also referred to assessment of capacity, acting in a patient's best interest and independent advocates (IMCA). We saw the policy also indicated advance directives should be taken into account. Advance directives record decisions patients or their representatives have made earlier and may include a decision to refuse life-sustaining medical treatments.

The practice had developed a protocol relating to consent. It set out the practice approach to consent and how the principles of consent would be put into practice. The protocol referred to implied and expressed consent. Implied consent is where a patient offers themselves for examination and expressed consent is written or verbal agreement to a procedure.

The practice devised a template for recording mental capacity assessments. One of the GPs told us its use ensured all aspects were considered. An example shared with us related to patients with a diagnosis of dementia being given influenza immunisations. The GP said the assessment would ask questions such as 'does the patient have capacity?', 'if not, what is in their best interest?' and 'what have they done in the past?'. The assessment would include relatives and consider whether any advance directive to refuse treatment was in place. Where mental capacity assessments were more complex, in the case of need for referral for an operation, a second opinion would be sought.

There was a patient leaflet regarding consent to medical examination and treatment. It explained how consent meant agreement to examination or treatment and how others could consent on behalf of a patient if they were unable to give consent themselves. The leaflet explained the information patients should be given in advance and the additional support they could have such as, a chaperone, interpreter or friend or family member to accompany them. The leaflet also described how the practice was a teaching practice and carried out research. Patients would be asked for their agreement for a trainee GP to be present and to participate in research.

The GP who provided the dermatology clinics obtained consent for taking photographs and for surgical procedures. The GP told us they recorded consultations carefully including telling the patient about the risks involved, such as scarring.

Good

Are services effective?

(for example, treatment is effective)

One of the receptionists told us when older patients had health tests and they wished for a relative to obtain the test results on their behalf, they obtained the patient's consent to disclose the results in advance.

There was information available in the waiting room relating to mental health support organisations.

The consent protocol referred to 'Gillick competence' where children under the age of 16 years could give consent to their own treatment if they had sufficient understanding and intelligence to understand what was proposed. Otherwise, parental consent was required. We spoke with one of the GPs about Gillick competence in relation to the prescribing of contraceptives to under 16 year olds. They told us they checked the young patients understanding and spoke to them about the risks of sexually transmitted diseases.

Health promotion and prevention

The practice actively promoted self-care where this was appropriate. The practice leaflet provided information relating to a number of minor illnesses such as back pain, coughs and colds, conjunctivitis, diarrhoea and vomiting, chicken pox and cystitis. It also contained a list of websites where further information could be found about other illnesses including flu, measles and mumps. In addition there was information relating to common medical emergencies such as chest pain and stroke and what to do in the event of these.

The surgery had a 'POD' where patients could use a touch screen device to undertake a number of routine health checks. All new patients were offered a health check.

A health education event was specifically held in relation to the health needs of male patients. It attracted 22 patients and was supported by practice staff and the patient participation group.

There was 100% take up for most child immunisation which was higher than the clinical commissioning group (CCG) area. The exception to this was the uptake of the measles, mumps and rubella immunisation which was slightly lower (89%) than the clinical commissioning group area average of 94%.

We saw a range of information leaflets in the practice waiting area including those relating to charities, health promotion and carers support group. In addition, as part of the Bridgwater Bay Foundation of GP practices, there were copies of the Foundation newsletter for patients. We saw the winter edition contained information about the winter vomiting bug (norovirus) and how to prevent it from spreading. The practice supervised patients who were recovering from drug addictions with the taking of recovery medicines.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

Patients were generally satisfied with the services provided by the practice. We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of patients undertaken by the practice's patient participation group (PPG). The national patient survey 2013/14 showed 84% of patients would recommend their practice to others with 10% unsure and 3% indicting they probably or definitely wouldn't. It showed 95% of patients reported a good overall experience with 92% satisfied with phone access and 81% satisfied with the practice opening hours. The PPG survey asked questions about access to the practice. It showed 70% of patients would not interact with the practice using the internet and 44% of patients did not know they could book routine appointments on line.

We saw the GP partners agreed to a patients' rights charter in November 2014. It committed the practice to ensure patients experienced "respectful and considerate care, in a considerate and supportive environment where their privacy was protected and dignity maintained". It identified that this type of care would be demonstrated by: patient's wishes being respected, respect for diversity and difference, patients being involved in decisions about their care and staff providing personalised care. It also stated patients' interests were to be given priority by staff and adopting an organisational culture where respect for the individual was valued.

The practice leaflet explained it aimed to offer appointments without excessive delay and to help prioritise, receptionists might ask for a brief outline as to why the appointment was needed. The leaflet explained how, for some, appointments with the practice nurse might be the most appropriate and reception staff could book patients for the right kind of appointment. The leaflet continued to explain how patient's confidentiality would be respected at all times.

The practice was involved in training GPs and medical students. This meant that sometimes appointments involved having a second GP or a student present during the appointment. The leaflet promised that patient's permission would be sought if this were to be the case.

Care planning and involvement in decisions about care and treatment

The practice leaflet explained how same day appointments were reserved for patients whose health had changed rapidly. It stated due to high demand for same day appointments patients would receive a telephone call from a GP for an initial assessment of the problem. The leaflet explained how some conditions could easily be managed by telephone and if the patient needed further assessment they would be invited in to the practice for an appointment.

The GPs offered telephone consultations for when patients needed to hear the result of tests and any suggested treatment. The practice was committed to ensuring, as far as possible, that it was the patient's own GP who telephoned to discuss test results and treatment with them.

We reviewed the most recent data available for the practice and saw the percentage of patients on the register of patients aged 75 years and over who had a comprehensive care plan documented in the records was lower than the national average for the same period. The practice had 44% of patients who had a care plan documented that had been agreed with the patient, their family and carers compared to 86% nationally.

Patient/carer support to cope emotionally with care and treatment

The practice considered the needs and support of carers. We spoke with the practice carers' champion. They told us they linked with the local carers group and had developed a leaflet aimed at giving carers information about the support available to them

The new patient registration pack asked the patient if they had caring responsibilities. This was recorded in the patient's record so it could be taken into consideration during any consultation.

The practice hosted regular carers meetings and training was provided by the local carers group.

A GP told us the practice always tried to contact the spouse of a patient who had died in order to offer condolences. They said they would refer to a counselling charity if it was appropriate. The practice listed the names of patients who had died and circulated this information so that staff were made aware.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. The practice patient registration list had grown significantly from 2006 and there was further growth in patient numbers with house building increasing in the area. The practice took this into account when designing the new medical centre and there was room for expansion within the building.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. These included patients whose first language was not English, travellers and patients with disabilities.

The practice had compiled a disability protocol. It reflected how the practice would meet the needs of patients with disabilities including in relation to the premises and information along with staff training and skills.

There was level access throughout the practice and a portable induction hearing loop at the reception desk.

The practice maintained a register of patients with hearing loss. This meant the GPs were alerted when such patients were at the practice for appointments and the GP could collect them from the waiting room.

The consulting rooms had adjustable examination couches to assist patients with limited mobility. The seats in the waiting rooms had arms to make them easier to get in and out of.

The electronic 'arrival system' was in English and Polish to enable those who were registered with the practice and for whom Polish was their first language to sign in. We saw signs in the waiting room in several languages. One of the GPs had learnt some Polish phrases to enable them to communicate effectively.

A GP told us about the access to a translation service, using speaker phone, for patients whose first language is not English. This helped to ensure the patients understood the content of any consultation to optimise their care.

We saw the record of a significant event where a patient whose first language was not English appeared to understand during the consultation but had not. This led to missed hospital appointments. When the practice realised the patient had not understood they asked the patient to make an appointment where a telephone interpreter service was used and this worked well.

Some of the patients were from the travelling community. We were told by one of the GPs there were several static sites in the area and the practice tried to accommodate those who lived on the sites. The GP said the practice aimed to be more facilitative and tried to be flexible with immunisations.

Access to the service

The practice opening hours were from 8.00 am until 6.30 pm on weekdays. There were extended opening hours from 6.30 pm until 8.00 pm every third Monday and the practice offered appointments from 8.30 am until 12.00 noon on every sixth Saturday. The practice manager told us according to the patient list size the number of hours of extended appointments exceeded that contractually required.

The catchment area for patients was determined by the ability of the practice to provide home visits and any patients who were moving outside of the area were asked to register with a practice close to their new address.

Appointments and requests for repeat prescriptions could be made in person, by telephone or through the on-line booking system.

There were a range of appointment types. Some were routine, pre-bookable and there were same day emergency appointments that were triaged along with telephone consultations. There were also appointments available with nurses and healthcare assistants, a dietician and midwife. The triage GP called patients back as soon as possible and then saw the patient based on need and the patient's requirements. This system was introduced between three and six months ago and the practice was in the process of auditing the arrangements. One of the GPs said they felt the triage arrangements were safe as they enabled rapid access for example, to an appointment for a child who was ill. We saw full records maintained of triage that led to an appointment within two hours and led to follow up surgery.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Routine appointments could be usually fitted in within a week. If a patient objected they were given a same day triage call. Home visits were available for those patients who were housebound or where their condition made them too ill to attend an appointment.

The practice aimed to deliver the same level of service and support to all its patients including those with hearing loss, sight loss, those with learning disabilities and those for whom English was not their first language. It had considered the needs of these groups and developed a specific patient access policy. The policy outlined how staff should respond to the patient's needs including, offering support.

The national patient survey for 2013 showed 94% of patients described their experience of making an appointment as 'good'.

Listening and learning from concerns and complaints

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

The complaints policy was outlined in the practice leaflet. It stated complaints would be acknowledged within three working days with a further response within 14 days. Any complaint would be investigated and the outcome of the investigation would be put in writing and sent to the complainant.

The policy included offering the complainant a meeting with the practice to discuss the investigation and its findings, if they were dissatisfied. If they remained unhappy with the outcome after the meeting they could pursue their compliant with the health services ombudsman.

The practice manager was the responsible person for handling complaints having had previous experience of this. One of the GPs described the complaints process as 'open' with clear communication and information. They said the practice aimed to determine what outcome the complainant wished for.

We saw there were lessons learnt from complaints investigations. The complaints quarterly returns showed us the date the complaint was received was recorded along with, the nature of the complaint, further details and actions taken. The returns also showed the lessons learnt and the date the complaint was closed.

Complaints received by the practice included some about reception staff, clarity of communication and lack of continuity of GP. There were records of the lessons learnt and actions taken by the practice in respect of all of these including customer service training.

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 practice mission, vision and values were outlined in the patient leaflet and on its website. It aimed to provide all its patients with "comprehensive health care services of the highest quality within available resources". It referred to patients being given "care that recognises the individual" and reflected its commitment to "quality care, respect and dignity, compassion and empathy and working together for patients". It stated it would do this by learning and improving.

The practice had considered future recruitment need to meet the demand for services in succession planning. As part of this it was engaging with the Equality and Diversity Forum so that it would be able to meet the needs of any population group growth.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. For example there was a lead nurse for infection control and each of the partner GPs had specialisms. The staff we spoke with were clear about their roles and the roles of other staff. Staff told us the best thing about working in the practice was the staff team who all got along well together. All staff said they felt valued and were proud to work in the practice.

Policies and procedures were available on the practice internal computer system. Staff knew where to find policies. We looked at a range of the policies and saw they were kept up to date.

The practice manager and deputy manager had an open door policy and staff told us they were approachable. Staff said they could go the practice manager, deputy or any of the GPs for support if needed.

A range of meetings were held. These included the weekly meetings to focus alternately on clinical and non-clinical issues. One week there was a meeting with community nurses, health visitors and hospice staff to focus on the needs of vulnerable patients, children at risk and patients with palliative care needs. The meeting to reflect on non-clinical issues considered new research and guidance, practice issues and matters relating to the business.

Full staff meetings were held two to three monthly and nurses met every month. One of the nurses told us this provided the opportunity to reflect on practice. They said there was an opportunity on a daily basis to meet and share ideas or concerns with other nurses.

Leadership, openness and transparency

The practice manager met regularly with the partners in the practice to discuss the development of the service. Information was cascaded to staff and there were mechanisms for staff to become involved in discussions about developments.

We saw from minutes that team meetings were held regularly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

We saw the practice was carrying out research in relation to diabetes, coronary and arterial disease and the early diagnosis of cancer.

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

The practice had an active Patient Participation Group (PPG). The PPG had a history of involvement in the medical centre having been established at the Brent House surgery. It was involved in choosing the colour scheme for furnishings and the chair of the PPG led the opening ceremony of the medical centre.

The PPG actively engaged with patients to seek feedback and acted as "eyes and ears" for the practice management. Where changes were made to the operation of the practice the PPG acted as intermediary to provide patient views.

The PPG communicated with patients by use of a notice board and its profile on the practice website. It was involved in the men's health event provided by the practice and helped to run a carers event in the town hall. There was also a newsletter produced by the PPG. We saw the November issue made reference to the surgery POD where patients could use a touch screen device to undertake a number of routine health checks. It also gave information about support for carers, the flu immunisation service, and patient survey results.

The practice also had a 'virtual' PPG made up of patients who did not want to attend meetings but were happy to contribute by responding to surveys. We were told the virtual PPG was increasing in numbers steadily.

Are services well-led?

Good

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

The PPG were actively recruiting new members. It had produced a leaflet asking patients if they were interested in participating by becoming involved. The leaflet described how patients could be involved and how to apply.

Management lead through learning and improvement

Staff told us they enjoyed working at the practice and were proud of the work they did. They said they felt supported and enjoyed socialising together.

All staff had annual appraisal that led to the completion of a personal development plan. Staff told us annual appraisals were due in November 2014 and spoke positively about the training opportunities this led to.

We saw there were a range of opportunities for staff learning and development. Clinical meetings provided a forum for training on alternate weeks when there was sharing of good practice. There were other in-house meetings when training was provided. Administrative and reception staff told us about the 'team' meetings they attended.