Dr Trill and Partners

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?	Outstanding
Are services well-led?	Good

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Exmoor Medical Centre (Dr Trill and partners) on Wednesday 5 November 2014. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, effective, safe and well led services. They were good for providing services for the patients experiencing mental health problems, families, children and young patients, older patients, working age and retired patients and patients' with long term conditions. They were outstanding for providing responsive services and for providing services for patients living in vulnerable circumstances.

Our key findings were as follows:

- The practice prided itself in offering same or next day appointments to all patients. If patients were unable to visit particular times of the day the GPs would try to accommodate the patient on an individual case basis so they were seen.
- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients praised staff highly for their compassion, respect and efficiency and had confidence in their ability to diagnose and treat their problem effectively and appropriately.
- The practice had good systems to communicate with patients, online services, such as a patient blog and newsletters and an active patient participation group.
- The practice had effective communication and liaison systems in place with local community support, health and advice services.
- 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

Summary of findings

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

We saw several areas of outstanding practice including:

- The practice dispensing staff contacted every patient within a week of being discharged from hospital to check and review their prescription medicines and any additional support required. GPs would contact the patients for any complex medical concerns.
- The practice had well developed links with the community and was involved in fundraising for improving patient care in the local area. This included setting up a patient funded volunteer group to deliver prescriptions to patients' homes in the area and also to four set locations within nearby villages. They also had an active involvement in the community such as through fund raising events and support of fitness programmes and updated patients through their practice website on a patient blog.
- Additionally we were told staff would go above and beyond their duty to help and support patients, when required. Staff had been known to drop prescriptions off to patients on their way home from work and take patients home from appointments. Also, found temporary accommodation for a homeless person who had mental health problems and ensure another patient who needed to be admitted to hospital went in a dignified manner. Staff had also recognised when a carer had to be admitted to hospital that arrangements were in place to assist their partner in their absence.
- The practice coordinated a benefits advisory service once a week in the practice, for patients to use free of charge. The practice demographic was in the middle range for deprivation. This service enabled patients to get the advice they needed from a local centre, which may be difficult for some patients to gain this advice normally because of where they live and travel barriers.
- The practice had a comprehensive contingency plan to deal with the challenges the practice faced in bad weather, such as snow. The practice had arrangements with local services, such as the local bed and breakfast to provide accommodation for a GP and farmers to help deliver critical medicines, or take GPs for home visits to their most vulnerable patients using their tractors or quad bikes. Pre-planning arrangements were in place for patients to collect two month's supply of prescriptions over the winter period.
- The practice has recently recruited an educational psychologist to provide advice and support for children and families who require additional support. The local child and adolescent mental health service normally see referred patients with complex mental health problems. The practice will be providing a service for its patients who need lower level support.
- There was a lead member of staff who was a carer champion to help support registered carers. Also, the practice facilitated the local carers group at the practice where 10-15 carers attended each month along with the practice carers champion.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

The practice had a comprehensive contingency plan to deal with the challenges the practice faced in bad weather, such as snow. The practice had arrangements with local services, such as the local bed and breakfast to provide accommodation for a GP and farmers to help deliver critical medicines, or take GPs for home visits to their most vulnerable patients using their tractors or quad bikes. Pre-planning arrangements were in place for patients to collect two month's supply of prescriptions over the winter period.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings showed systems were in place to ensure all GPs, clinical pharmacist and nursing staff were up to date with both national guidelines and other locally agreed guidelines. Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff worked well with multidisciplinary teams. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff.

Are services caring?

Good

The practice is rated as good for providing caring services. National GP patient survey data showed that patients rated the practice higher than others for several aspects of care. Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment. Information to help patients understand the services available was easy to understand. We also saw that staff treated patients with kindness and respect, and maintained confidentiality.

Additionally we were told staff would go above and beyond their duty to help and support patients, when required. Staff had been known to drop prescriptions off to patients on their way home from

Summary of findings

work and take patients home from appointments. Also, found temporary accommodation for a homeless person who had mental health problems and ensure another patient who needed to be admitted to hospital went in a dignified manner. Staff had also recognised when a carer had to be admitted to hospital that arrangements were in place to assist their partner in their absence.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. They acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Local Area Team and Somerset Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment and a named GP or a GP of choice, with continuity of care and 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 the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

The practice coordinated a benefits advisory service once a week in the practice, for patients to use free of charge.

The practice had recently recruited an educational psychologist to provide advice and support for children and families who required additional support.

The practice had an active involvement in the community such as through fund raising events and support of fitness programmes. The practice actively updated patients through a blog on the practice website.

Due to where the practice was based in a rural part of Somerset a patient funded volunteer group had been initiated by the practice to deliver prescriptions to patients' homes in the area and to four set locations within nearby villages.

Are services well-led?

Good 

The practice is rated as good for being well-led. The practice had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held

Summary of findings

regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was active and listened to by the practice.	

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population. They had just started a range of enhanced services. For example, dementia and end of life care. The practice planned to develop the end of life enhanced service to work towards gaining the gold standards framework benchmark for end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

The practice offered appointments around local transport times to help suit the patient. All patients over 75 years old had been allocated a named GP. There were five patients who were on the palliative care register and the practice worked closely with the community nursing team to ensure the patient received the best possible care.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. There were emergency processes and referrals made for patients whose health deteriorated suddenly. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check their health and medicine 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 provided additional enhanced services and equipment to benefit patients, such as in house blood coagulation testing, a weekly clinic run by a specialist nurse for leg ulcers and complex wound care and a weekly clinic by an external diabetes specialist nurse. The practice also had additional equipment for patients to use to reduce visits to local hospitals, such as spirometer (which assists with the diagnosis of lung conditions) and 24 hour blood pressure monitoring machine and a 24 hour electrocardiogram (ECG). The additional equipment reduces the need for patients to be referred to secondary care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were 'at risk'. For example, children and young people who had a high

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number of A&E attendances. Immunisation rates were just below local area average for all standard childhood immunisations. Parents were sent reminders and the practice had a system for reminding patients to receive their immunisations.

Appointments were available outside of school hours and children were given priority for same day appointments, when required. The practice had recently approached the local school to provide health advice and support to the children.

The premises were suitable for children and babies including a child play area and nappy changing facilities. We heard good examples of joint working with midwives and health visitors.

The practice had recently recruited an educational psychologist to provide advice and support for children and families who required additional support.

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.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless patients, travellers and those with a learning disability. The practice had carried out annual health checks for patients with a learning disability and 100% of these patients had received a follow-up. They offered longer appointments for patients with a diagnosed learning disability, when necessary. Staff had attended a session about learning disabilities to aid their understanding of this condition.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. The practice had informed vulnerable patients how to access various support groups and voluntary organisations. The practice was proactive in assisting patients in need. We heard of one example where the practice had

supported and assisted a homeless person to find temporary accommodation. The practice had processes in place to ensure patients who were homeless had access to their health information and prioritised their appointments so they could be seen promptly.

The practice facilitated regular monthly carers meeting for approximately 10-15 carers and had a carers champion to support all registered carers in the practice.

Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with a diagnosis of dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. The practice carried out advanced care planning for patients with a diagnosis of dementia. They had signed up to an enhanced care service for patients with a form of dementia. The practice referred patients to local memory clinics for further assessment, when required. Patients were signposted to local support groups and memory clinics.

The practice told patients experiencing poor mental health about how to access various support groups and voluntary organisations. The practice had a talking therapy team which visited the practice once a week for patients suffering from mental health problems. There was also a counselling service available for patients if there was demand, the practice would arrange for counsellors to visit the practice on an ad-hoc basis. The practice had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

During our inspection we met with the practice patient participation group (PPG) which was formed in 2004. There are currently 19 members and we met with four of the PPG members. They told us the practice was committed to improving patient care and included the PPG in the decision making when changes were planned.

We received six comment cards all patients who had commented were highly satisfied with the service received. During our inspection we spoke with five patients, four out of five patients were very complimentary about the practice. One patient commented about the consistency of care because patients often saw trainee and locum GPs. However, they were aware there had been a sudden absence with one of the GP partners which had impacted on this.

The practice had completed the friends and family test throughout October 2014, a new national initiative for GP practices to ask their patients would they recommend the service to their friends and family. We were told 91% of the 55 patients surveyed had responded saying they would recommend the practice to friends and family.

The practice had completed its own survey for April 2013 to March 2014, 82 patients had completed a survey with 88% of patients rating the practice as good, very good or excellent. The main areas for improvement were the comfort of the waiting room and the wait time to be seen for an appointment. Both of these areas have improved over the past three years through previous surveys. Since this survey the practice had amended the morning sessions to include a coffee break and catch up to avoid delays and the impact on patient time. Receptionists now asked patients for more specific information about their appointment before it is booked so they allocate more time, if necessary. There was also a register for patients who had been assessed as requiring more time at appointments so the receptionists could automatically book in longer appointments for these patients.

Prior to our inspection we reviewed other information sources of what patients experienced with the service provided. This included NHS choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had not been any comments made about the practice in the last year.

We also reviewed the national GP patient survey taken from patients for the periods of January to March and July to September 2013. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 117 patients had completed the surveys from the 246 sent. We saw 94% of patients surveyed said their overall experience of the practice was good with 98% of patients saying they trusted and had the confidence in the last GP with whom they spoke.

Outstanding practice

The practice dispensing staff contacted every patient within a week of being discharged from hospital to check and review their prescription medicines and any additional support required. GPs would contact the patients for any complex medical concerns.

The practice had well developed links with the community and was involved in fundraising for improving patient care in the local area. This included setting up a patient funded volunteer group to deliver prescriptions to patients' homes in the area and also to four set locations within nearby villages. They also had an active involvement in the community such as through fund raising events and support of fitness programmes and updated patients through their practice website on a patient blog.

Additionally we were told staff would go above and beyond their duty to help and support patients, when required. Staff had been known to drop prescriptions off to patients on their way home from work and take patients home from appointments. Also, found temporary accommodation for a homeless person who had mental health problems and ensure another patient

who needed to be admitted to hospital went in a dignified manner. Staff had also recognised when a carer had to be admitted to hospital that arrangements were in place to assist their partner in their absence.

The practice coordinated a benefits advisory service once a week in the practice, for patients to use free of charge. The practice demographic was in the middle range for deprivation. This service enabled patients to get the advice they needed from a local centre, which may be difficult for some patients to gain this advice normally because of where they live and travel barriers.

The practice had a comprehensive contingency plan to deal with the challenges the practice faced in bad weather, such as snow. The practice had arrangements with local services, such as the local bed and breakfast to provide accommodation for a GP and farmers to help deliver critical medicines, or take GPs for home visits to their most vulnerable patients using their tractors or quad bikes. Pre-planning arrangements were in place for patients to collect two month's supply of prescriptions over the winter period.

The practice has recently recruited an educational psychologist to provide advice and support for children and families who require additional support. The local child and adolescent mental health service normally see referred patients with complex mental health problems. The practice will be providing a service for its patients who need lower level support.

There was a lead member of staff who was a carer champion to help support registered carers. Also, the practice facilitated the local carers group at the practice where 10-15 carers attended each month along with the practice carers champion.

Dr Trill and Partners

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 advisor and a CQC pharmacist.

Background to Dr Trill and Partners

We inspected the location of Exmoor Medical Centre, Oldberry House, Fishers Mead, Dulverton, TA22 9EN, where all registered regulated activities were carried out.

The practice serves approximately 3900 patients and covers a 300 square mile area in rural west Somerset. The practice has 600 of 3900 patients living in Devon, which brings its own challenges of divided healthcare services over two counties. In 2009 the practice moved its base to a newly purpose built premises. The partners in the practice had subsidised the funding for the new building along with some funding from the Primary Care Trust (previous commissioners of GPs).

The practice arranges for other health care professionals to use the practice on a regular basis to provide patients with a regular service. This includes community nurses, psychotherapist, midwife and health visitor, dietician, counselling and the opticians. This is an extensive building which is able to provide additional non-NHS services to the local community, such as chiropody, cognitive behavioural therapy with a qualified psychologist, osteopathy and audiology (hearing aid specialist) services. There is also an un-associated dental practice based in the practice.

The national general practice profile shows the practice has a large demographic of patients over the age of 50 years old over the England and Somerset Clinical Commissioning Group (CCG) average particularly between the ages of 60 to 69 years old. The practice is under the national and CCG average for patients under 44 year olds. The practice is in the middle range for the level of deprivation in the area.

There were three partners, two GPs and a practice manager. One of the GP partners was currently on long term absence and was being covered by a long term locum in the interim. The practice also had recently recruited a salaried GP who started in August 2014. The practice was a registered GP training practice and currently had one GP registrar working in the practice. A registrar is a qualified doctor who requires additional experience in a GP practice to qualify as a GP. Each week the GPs covered 21 sessions which is the equivalent to two full time GPs. There were three female GPs and one male GP.

The nursing team consisted of two female practice nurses, equivalent to one full time nurse and a female health care assistant.

The practice had a dispensary to enable them to dispense prescription medicines to patients' who lived more than one mile away from the practice. Within the dispensary there were three dispensing staff members who delivered this service.

The practice had a General Medical Service contract with NHS England. The practice referred their patients to another provider for out of hours services to deal with urgent needs when the practice was closed.

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We spoke with the Somerset Clinical Commissioning Group, NHS England local area team, Somerset Local Medical Council and local area Healthwatch. We carried out an announced visit on the 5 November 2014. During our visit we spoke with a range of staff including the main GP partner, a salaried GP and a trainee GP, the practice manager, a practice nurse, medical secretary, dispensary staff and a receptionist. We also spoke with nine patients including four members from the patient participation group and reviewed six comment cards where patients shared their views and experiences of the service prior to our inspection.

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, updates from the National Institute of Health and Care Excellence and national patient safety alerts. The staff we spoke with were aware of their responsibilities regarding how to raise concerns, and knew how to report incidents and near misses. For example, a receptionist was concerned about a patient who was displaying signs of abuse. They had reported this to the GP who then acted in response to the situation sensitively and appropriately. Practice staff could access incident forms on the computer system and there was an open environment for staff to report their concerns to the practice manager or GPs.

We reviewed the significant events and complaints over the last year. We saw practice meeting minutes discussed these incidents and how the practice could improve service provision to prevent recurrence.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of significant events that had occurred during the last year. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence the practice had learned from these and the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff felt comfortable to raise an issue for consideration at the meetings and they felt encouraged to do so by the partners.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. We saw evidence of action taken as a result of an urgent referral which had not been received by the hospital. The practice had now changed their procedures and they now phoned the hospital to confirm referrals had been received.

National patient safety alerts and latest national guidance updates were disseminated through GP educational meetings and emails to practice staff.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children and adults. We looked at training records which showed all staff had received relevant training about safeguarding vulnerable adults in October 2013 and child protection in March 2013. We were told by the GP partner staff received specific level training depending on their role. They had completed level three training in child protection as they were the lead practitioner for safeguarding. The other GP employed had been recruited in August 2014 and the practice would ensure they were level 3 trained by August 2015. They were currently level 2 trained. Nursing staff had completed level two and level one training was completed by the receptionists/administrators for child protection.

Staff we spoke with knew how to recognise signs of abuse in vulnerable adults and children. We heard of an example of when reception staff had a safeguarding concern about a patient and had escalated it to the GP partner. They were also aware of their responsibilities in raising a concern and how to contact the relevant agencies in working hours and out of normal hours. We saw contact details were easily accessible to staff on the shared computer system. All staff we spoke with were aware who these lead practitioners were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example, children who were subject to a child protection plan.

We saw the practice had a chaperone policy and posters in the waiting area advertising the option to patients. Receptionists who chaperoned for patients had received training.

GPs ensured risks to children and vulnerable adults were flagged on the patient record system. This enabled practice staff to be aware these patients may need additional support and monitoring.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a

clear policy for ensuring these medicines were kept at the required temperatures. This was followed by the practice staff, and the action to take in the event of a potential failure was described.

Processes were in place to check these medicines were within their expiry date and suitable for use. Expired and unwanted medicines were disposed of in line with waste regulations. Suitable emergency medicines were kept in the practice.

Vaccines were administered by nurses using directions that had been produced in line with legal requirements and national guidance.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in the practice. This helped to ensure patient's repeat prescriptions were still appropriate and necessary. There was a system in place for the management of high risk medicines which included regular monitoring when necessary. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

There was a proactive approach to anticipating and managing risks to patients was embedded and recognised as the responsibility of all staff. When prescriptions were changed or updated, for example after discharge from hospital, any changes made were authorised by a GP. Any patients discharged from hospital received a phone call from dispensary staff to check they had sufficient supplies of medicines, and any other support they required.

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

Dispensing staff at the practice were aware prescriptions should be signed before they were dispensed. For those prescriptions not signed before they were dispensed they were able to demonstrate these were risk assessed and a process was followed to minimise risk. We observed this process was working in practice. The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients from their dispensary.

There was a system in place to ensure medicines requiring cold storage were kept at the correct temperature, however there was no monitoring of room temperature in the dispensary to show that other medicines were stored correctly.

We saw records which showed all members of staff involved in the dispensing process had received appropriate training and had regular checks of their competence.

The practice had established a service for patients to pick up their dispensed prescriptions at four locations and had systems in place to monitor how these medicines were collected. They also had a home delivery service which patients could choose to use. They also had arrangements in place to ensure patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

We observed the practice was clean and tidy. Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

All nursing, dispensing and administration staff had received infection control training in September 2014. We saw evidence that the lead had carried out an audit for infection control in January 2014 with no improvements identified.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use to comply with the practice's infection control policy. Hand washing sinks had hand soap and hand towel dispensers were available in treatment rooms and patient and staff toilets. The practice should ensure disposable curtains used in treatment rooms were changed every six months.

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a germ found in the environment which can contaminate water systems in buildings). The practice had carried out a risk assessment in September 2014 and found the risk was low and no additional action was required.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly. All portable electrical equipment was routinely tested annually in October and displayed stickers indicating the last testing date. We saw evidence of calibration of relevant equipment; for example weighing scales and the spirometer (a piece of equipment to assist in diagnosing lung conditions). Calibration of equipment was routinely checked annually and was due in December 2014.

Staffing and recruitment

We reviewed two recruitment records of staff who had been employed in the last year. The records contained evidence of appropriate recruitment checks that had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal record checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards to follow when recruiting clinical and non-clinical staff. The practice had carried out a risk assessment in November 2014 for members of staff who did not require a criminal record check. This had identified staff who carried out chaperoning required a criminal record check and these were in process of being completed.

Staff told us about the arrangements for planning and monitoring the numbers and skill mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure there were enough staff on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. If cover was required for GPs on long term sickness then the practice would use long term locums to cover this period.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had recently discussed health and safety precautions at a staff meeting so staff were aware of additional safety precautions had been identified.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed the majority of staff had received training in basic life support in October 2014. Emergency equipment was available including access to oxygen, adult and child Oximeters and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Records confirmed emergency equipment and medicines were checked on a monthly basis to ensure they were kept within their expiry date. We spoke with a member of staff who informed us of a recent medical emergency that had occurred. The staff involved had discussed the situation and decided learning from this. However this was not followed through and had not been logged as a significant event and learning identified as a team. We were informed this did not follow their normal procedures and this would be followed up with the staff involved.

A business continuity plan was in place to deal with a range of emergencies which may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building.

The practice had carried out a fire risk assessment in January 2013 that included actions required to maintain fire safety. Records showed staff were up to date with fire training and they practised regular fire drills.

Good

Are services safe?

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We heard an example of this when a GP had taken sudden unexpected long term sickness and mitigating actions had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

The practice nurse told us they and the other nurses led in specialist clinical areas such as diabetes, respiratory conditions and asthma. GPs and nursing staff we spoke with were very open about asking for and providing colleagues with advice and support.

The senior GP partner showed us data from the local Clinical Commissioning Group of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and a regular review annually. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice dispensing staff contacted every patient within a week of being discharged from hospital to check and review their prescription medicines and any additional support required. GPs would contact the patients for any complex medical concerns.

We spoke with the medical secretary regarding the process for referrals. The computerised system highlighted urgent referrals initiated by the GP and these were always completed as a matter of priority and always by the end of the working day. If the medical secretary was not working then GPs would take responsibility to ensure referrals were addressed promptly. All referrals were usually completed within 48 hours. We were told referrals were discussed at meetings where necessary and improvements to practice were shared with all clinical staff. For example, an urgent referral had been sent to the local hospital and the practice had received a confirmed fax. However the patient did not receive an appointment. The practice now phones the hospital after each urgent referral was made to ensure it had been received and action had been taken.

We saw there was no evidence of discrimination when making care and treatment decisions.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice showed us three clinical audits that had been undertaken in the last two years. One of these audits was completed in August 2014 following new published NICE guidance from 2014 in relation to atrial fibrillation (heart condition). This audit had demonstrated changes to three patients following an educational session which patients had attended. The practice had re-audited and demonstrated improvements following the previous audit. Another audit had been carried out on patients with gout (pain or swelling in joints) based on recent research into the condition. This had shown a number of patients required a review, which was part of the audit actions and was due for review in December 2014.

The practice had opted out of the quality and outcomes framework and had joined other practices in Somerset to use the Somerset practice quality scheme.

Staff regularly checked patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had just signed up to the gold standards framework for end of life care in November 2014. This was because they had recognised this was an area for improvement within the practice. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

Good

Are services effective?

(for example, treatment is effective)

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff (except those who were not working on training days) were up to date with attending mandatory courses such as annual basic life support and safeguarding children and vulnerable adults.

All staff underwent an annual appraisal that identified learning needs from which personal development plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example the practice had funded for a dispensary staff member to complete an additional qualification. The practice was a GP training practice, doctors who were training to be qualified as GPs. We were told they had access to a senior GP throughout the day for support. Specified supervision times were provided during each session and patients were given longer appointment times with the trainee doctor.

Practice nurses were expected to perform defined duties and were able to demonstrate they were trained to fulfil these duties. For example, training in the administration of child, flu and travel vaccines. Those with extended roles for seeing patients with long term conditions such as asthma, chronic obstructive pulmonary disease and diabetes told us they had received appropriate training to fulfil these roles.

We spoke with the practice manager about how they would deal with poor performance that had been identified with staff. We heard of an example of when an issue had been raised and appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient needs and manage complex cases. The practice received either electronically or by post diagnostic test results, such as blood test results and letters from the local hospitals including discharge summaries and out-of-hours GP services when patients had used these services. Staff were clear of their responsibilities and other staff responsibilities in dealing with this correspondence and acting on any issues arising from communications with other care providers on the day they were received. One hospital had an electronic system which would email patient results directly to the patient's GP who was responsible for taking any action for these results. If this GP was unavailable the GPs had a duty system where they would check each other's results to ensure urgent actions were dealt with promptly. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

Due to the practice having a small patient base and the community nursing team being based in the practice individual patients were routinely discussed when concerns or issues arose. Staff felt this system worked well and remarked on the usefulness of having the community team onsite as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made 100% of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported this system was easy to use and recognised some patients may find the system complex to use and would provide further support to these patients.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to accident and emergency. The practice has signed up to the electronic Summary Care Record. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record system to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. Staff had received additional training in understanding the codes used for particular conditions and how to the use the system effectively.

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. Staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. Patients with a learning disability and those with a form of dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans had been reviewed in September 2014 (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision.

All GPs demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

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

Health promotion and prevention

The practice asked all of their new patients to complete a lifestyle questionnaire when joining the practice. This enabled the GP to review any health concerns detected and arrange for these to be followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18-25 and offering smoking cessation advice to smokers.

The practice was about to start offering NHS health checks to all its patients aged 40-74. The nurse told us they had completed their training for these checks and would be sending the first batch of letters to patients shortly after flu vaccinations had been completed.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all six had received an annual physical health check. Where the practice had identified the smoking status of patients over the age of 16 they had actively encouraged nurse-led smoking cessation clinics to these patients. There was evidence the smoking clinics were successful because 18 patients who had stopped smoking in the last 12 months. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Patients had access to a room in the waiting area where they could check their height, weight and blood pressure before or after their consultation. This provided encouragement for patients to take further responsibility to monitor their own health independently alongside the care and treatment offered by the GP or nurse.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all child immunisations was slightly below average for the CCG. There was a clear procedure for following up non-attenders by the administration team and nursing staff.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national GP patient survey where 117 patients were surveyed in 2013 and an additional patient questionnaire undertaken by the practice's patient participation group (PPG) in 2014. The evidence from all these sources showed patients were satisfied with how they were treated and were shown compassion, dignity and respect by staff when they visited. We saw 94% of patients surveyed from the national GP patient survey said their overall experience of the practice was good with 98% of patients saying they trusted and had the confidence in the last GP with whom they spoke.

Patients completed CQC comment cards, prior to our inspection, to tell us what they thought about the practice. We received six completed cards and the majority were all positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. During our inspection we spoke with five patients, four out of five patients were very complimentary about the practice. One patient commented about the consistency of care because patients often saw trainee and locum GPs. However, they were aware there had been a sudden absence with one of the GP partners which had impacted on this.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room. Disposable curtains were provided in consulting rooms and treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard by others.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. Reception and administration staff answered patient calls away from the reception desk following feedback from the PPG group. The practice had also added additional sound proofing to the reception area to help with confidentiality. Next to the reception desk there was a patient room which receptionists and patient could use for confidentiality. Signs were displayed advertising this room to patients. This prevented patients overhearing potentially private conversations between patients and reception staff.

There was not a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. However, receptionists told us they had received training to help them understand and diffuse potentially difficult situations.

There was a strong, visible, person centred culture. Staff were highly motivated and inspired to offer care that was kind and promotes patients dignity. We were told staff would go above and beyond their duty to help and support patients, when required. Staff had been known to drop prescriptions off to patients on their way home from work and take patients home from appointments. Also, find temporary accommodation for a homeless person who had mental health problems and ensure another patient who needed to be admitted to hospital went in a dignified manner. Staff had also recognised when a carer had to be admitted to hospital that arrangements were in place to assist their partner in their absence.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 89% of practice respondents said the GP involved them in care decisions and 92% felt the GP was good at explaining treatment and results. The results from the practice's own satisfaction survey showed between 81-87% of the patients were satisfied the GPs ability to listen, explain, reassure, instil confidence in their ability, respect, consideration and concern for the patient.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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. Patient feedback on the comment cards we received was positive and aligned with these views.

Good

Are services caring?

Staff told us translation services were available for patients who did not have English as a first language. The receptionists had details of translation services which could be contacted if necessary. However, we did not see notices in patient areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and on the TV screen explained to patients how to access a number of local support groups and organisations for emotional or health care support. The practice accommodated benefit advisors to use the practice facilities once a week to help support patients who may be struggling with their finances.

Patient's emotional and social needs were seen as important as their physical needs. The practice had facilities to support patients who had caring responsibilities for a friend or relative. There was a lead member of staff who was a carer champion to help support registered carers. Also, the practice facilitated the local carers group at the practice where 10-15 carers attended each month along with the practice carers champion. The practice's computer system alerted staff if a patient was a carer to provide them with additional support, where required.

Outstanding ☆

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 patients 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 had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG) and patient surveys carried out. Patient feedback showed the main areas for improvement were the time a patient waits after their appointment time and the comfort of the waiting room. The practice had taken action to address the areas such as, memory foam cushions added to seating in the waiting area and adding in a catch up break in the morning session to help reduce patient waiting times.

There were innovative approaches to providing integrated person-centred pathways of care that involved other service providers. The practice coordinated a benefits advisory service once a week in the practice, for patients to use free of charge. The practice demographic was in the middle range for deprivation. This service enabled patients to get the advice they needed from a local centre, which may be difficult for some patients to gain this advice normally because of where they live and travel barriers.

The practice had recently recruited an educational psychologist to provide advice and support for children and families who require additional support. The local child and adolescent mental health service normally sees referred patients with complex mental health problems. The practice will be providing a service for its patients who need a lower level support.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. The practice had a high patient base aged over 70 years old, approximately 20% of its patient base. There were also 15% of patients who lived in Devon the adjoining county, which had its own challenges for referring to secondary care in another clinical commissioning group area. There were less than 1% of patients with a diagnosed learning disability and a form of dementia. The practice recognised and encouraged carers to register as a carer with them to enable the practice to provide additional support, when required.

There was a proactive approach to understanding the needs of different groups of patients to deliver care in a way that meets these needs and promotes equality. The practice welcomed patients who had no fixed abode and we heard an example of when the practice went above and beyond to help a homeless patient with finding some temporary accommodation in coordination with the local church. Receptionists were aware if a homeless person visited the practice requesting an appointment they would need to try and accommodate them the same day whilst liaising with the GP.

There was a very small proportion of patients whose first language was not English. The practice had access to online and telephone translation services to help assist consultations, if required.

Staff had last received equality and diversity training in November 2012, as part of their information governance training. Staff we spoke with were aware of identifying patients individual needs and treating patients equally and as individuals.

The premises and services had been adapted to meet the needs of patients with a disability. The practice had automatic front doors and lifts to the first floor to assist patients who used a wheelchair or patients with prams. The reception desk was relatively high and so reception staff would lean over the desk to speak with patients who were in a wheelchair or they could speak to the patient privately in a room next to the reception desk. Patients who were hard of hearing could use the installed hearing loop at the reception desk.

We saw the waiting area was large enough to accommodate patients with wheelchairs and prams and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities.

Access to the service

Appointments were available from 8:30am to 6pm on weekdays. If a patient had requested an extended hours appointment then this would be agreed on an individual basis. Usually the practice offered extended hours on a

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Monday and Tuesday evening and early appointments on a Wednesday and Thursday morning. The practice had audited which patients were attending the extended hour appointments and only 20% were used by working patients.

We saw patients had to wait approximately one week to see their preferred GP at the time of the inspection. The practice prided themselves on being able to offer every patient an appointment either the same day (if urgent or a child was requiring an appointment) or the next day. Also they offer accessible appointments to patients, such as appointments according to local transport timetables or easy access to patients assessed as high risk, such as homeless patients or carers.

Comprehensive information was available to patients about appointments on the practice website and in the new patient information pack. This included how to arrange urgent appointments, home visits and how to book appointments through the website. There was also information for patients about how to receive urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave the telephone number they should ring depending on the circumstances. Information about the out-of-hours service was provided to patients within the waiting area.

Longer appointments were available for patients who had been assessed by the GP. Receptionists were encouraged to gain as much information as possible from the patient to determine if they needed longer appointment times. Home visits were made to patients after the GPs had assessed their need, GPs would often call the patient first to gain further information before attending. Home visits were then organised between the GPs on duty and the location of the visit.

Patients were generally satisfied with the appointments system. They confirmed they could see a GP on the same or next day if they needed to, or wait a bit longer to see their preferred GP.

The involvement with the local community was integral to how services were planned and ensured that services meet patient's needs. Due to where the practice was based in a rural part of Somerset a patient funded volunteer group had been initiated by the practice to deliver prescriptions to patients' homes in the area and also to four set locations within nearby villages. There could be up to a seven day wait for their prescription to be delivered.

Patients' individual needs and preferences were central to the planning and delivery of tailored services. The services were flexible and ensured continuity of care. The practice had a comprehensive contingency plan to deal with the challenges the practice was likely to face in the winter with bad weather, such as snow. The practice had arrangements with local services, such as the local bed and breakfast to provide accommodation for a GP and farmers to help deliver critical medicines or take GPs for home visits to their most vulnerable patients using their tractors or quad bikes. Pre-planning arrangements were in place for patients to collect two month's supply of prescriptions over the winter period.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system through the practice website or an information leaflet provided at the reception desk. Patients we spoke with were aware of the process to follow if they wished to make a complaint.

We saw the practice had received five complaints in the last 12 months and found these had been satisfactorily handled and in a timely way. We saw the practice was open and transparent and used complaints to improve the service provided. For example, one patient had complained about the faded car park markings and disabled parking signs. The practice acted on this and had repainted and purchased a new sign.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted upon. We saw minutes from the annual complaints

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

meeting which had been held in April 2014. All staff had attended and were able to contribute and learn from the complaints raised and any improvement that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality service tailored to meet the needs of the practice population. We found details of the vision and practice values were part of the practice's strategy and five year business plan. We spoke with nine members of staff and they were all aware of the practice strategy and vision. A systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. The practice vision and values included becoming a centre for health promotion and to work closely with other community groups. It was clear from our inspection that the practice was delivering the vision it portrays. The practice was based in large premises and leased out additional space for other health related professionals to provide their services, such as a dentist, optician, chiropodist and hearing aid audiologist.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We read five of these policies and procedures and saw they had been reviewed annually and were up to date, reflecting current guidance.

There was a clear leadership structure with named members of staff in lead roles. For example, the practice manager was the lead practitioner for infection control and the main GP partner was the lead practitioner for safeguarding. We spoke with nine members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns. The partners wanted an open flat hierarchy management system to encourage all staff to provide their honest views to help to continuously develop the practice.

The practice had an on-going programme of clinical audits which was used to monitor quality and systems to identify where action should be taken. For example, following new guidance published from the National Institute of Health and Care Excellence in relation to atrial fibrillation an audit was completed for patients who had this condition in August 2014. This audit ensured patients were reassessed based on the guidance and their medicines reviewed. The audit was carried out again and showed the practice had improved on the results from the last audit.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us their significant event log, which addressed a wide range of potential issues affecting patient safety, such as an urgent referral to the hospital that had not been addressed. We saw significant events and complaints were regularly discussed at quarterly team meetings, where all staff attended. We saw actions and learning points were discussed and policies were updated when necessary.

The practice held monthly partners meetings to discuss plans for the future and the services they provided. The main GP partner regularly sent the team emails to gain their views about particular subjects and provide an open forum for change. They used these views to make decisions about the services provided and how to run the practice effectively.

Leadership, openness and transparency

Practice team meetings were held monthly and all staff were invited to attend. Staff told us there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. The practice also held an annual away day for all the team and would arrange locum cover to enable all staff to attend.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example recruitment and whistleblowing policies which were in place to support staff. Staff we spoke with knew where to find these policies if required.

The practice had an active involvement in raising money for local health rated charities through participating in a number of local charity events, such as the partners at the practice competing in the local 'ironman/woman' contest, race for life runs and a book and DVD sale in the practice (bought in by patients). They had raised a significant amount in the last year for local charities and this had proved to be a good way for the practice to be a core part of the community. They kept an internet blog to keep patients informed of their fitness programme and many patients told the partners this had encouraged them to

Are services well-led?

Good

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

participate in more exercise and fitness. This showed that not only did the practice care about its patients but also wanted to invest time in the community and improve health care services as a whole.

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

The practice had gathered feedback from patients through the patient participation group, practice patient surveys, national patient surveys, friends and family test and complaints received. We read the results of the annual practice patient survey carried out over April 2013 to March 2014. We found the practice did act on feedback from patients and actively tried to improve the service provided. For example, the practice would often score lower than the national average for patients waiting for appointments. The practice had implemented new protocols for GP appointment sessions to help improve this for patients, such as allocating sections of the morning for catching up and allocated times for supervision with the trainee GP. If patients requested a call back then the practice was now trialling providing patients with a specific time they would be called back.

Innovative approaches were used to gather feedback from patients and the public, including patients in different equality groups. At the time of the inspection, the practice had actively updated patients through a blog on the practice website. This had proved to be very beneficial to communicate with patients and keep them to up to date with practice events. They also produced a newsletter to inform patients of these events for patients that did not use the internet. For example, the practice charity fundraising and updates of the GP partners absence. Patients we spoke with knew about these changes and so it was evident it had worked well. The practice had encouraged their patients to register online for making appointments and requesting repeat prescriptions. This had also proved effective because 51% of the practice patient base had enrolled in this service. The practice patient base was often a hard to reach group due to the population demographics for patients to sign up to online services.

The practice had an active patient participation group (PPG) of 19 members. The PPG had representatives from the majority of population groups including, older people and working age population. The PPG had quarterly meetings and one or two of the partners would attend each meeting. During our inspection we met with four members of the PPG and they told us the group worked well with the practice and were encouraged to provide ideas for improvement. We saw the results and actions agreed from the last patient survey, which was considered in conjunction with the PPG and was available on the practice website. The practice invited speakers to the PPG meetings including a carers group and local pharmacy. This enabled the PPG to be aware of the services available so they could inform patients, when necessary. The practice and PPG were aware they did not cover all age groups of the patient demographic. They decided to start a virtual patient group which currently had 10 members, future plans were to increase this to enable them to gain a wider range of views.

The practice had gathered feedback from staff through the staff annual away days, practice meetings, appraisals and informal discussions. Staff told us they would not hesitate to provide feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. Staff we spoke with told us they had received regular annual appraisals which included a personal development plan. Staff told us the practice was very supportive of training and they had guest speakers and trainers attended. For example, staff receiving training from an external source about learning disabilities.

The practice was a registered GP training practice. The practice would have one trainee GP at any one time. The GP trainer would provide tutorials every other week and would always be available for support on their appointment session days.

There was a clear proactive approach to seeking out and embedding new ways of providing care and treatment. The practice was keen to recognise what they needed to do to improve the service. There future plans were to develop their end of life care to a gold standard level following feedback from the patient participation group, determining if they could do anymore for carers and reviewing older patients that do not visit the practice.