Taunton Road Medical Centre

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Taunton Road Medical Centre on 8 September 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for Older patients, Patients with long-term conditions, Families, children and young patients, Working age patients (including those recently retired and students), Patients whose circumstances may make them vulnerable, and patients experiencing poor mental health (including patients diagnosed with dementia). There were some outstanding elements of care and treatment for patients with learning disabilities, those with mental health problems and mothers and babies.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks.
- 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 said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

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

We saw areas of outstanding practice:

- There were examples of involvement and input into mental capacity decisions from a visiting learning disability nurse and how in partnership with GPs they ensured the best patient outcome in the circumstances for 99 registered patients.
- Staff worked with social services and the police to ensure patient safety. We heard how staff supported a patient to go from the consulting room directly to an out of area refuge to ensure their safety. In another case where a plea for help was made, a patient and their children were taken directly from the practice to the police station to prevent further harm from a violent partner.
- In specific circumstances the practice continued to support patients who moved away from the practice area. A young patient diagnosed with an eating disorder who had continued to lose weight. A multi-agency decision was reached to detain this patient for their own protection under the mental health act legislation but the patient left the area. The patient wanted to remain with her GP and the practice agreed. The GP met the patient monthly. Records showed the patient slowly improved with their current BMI being considerably improved.
- The practice was a GP training practice and had three registrar GPs located at the practice at the time of the inspection. We saw one of the GPs who supported the registrar GPs had been awarded "Best GP year 5 trainer" for 2015. The registrar we spoke with commented on the high quality of support and mentoring provided within the practice.

Additionally there were areas of practice where the provider needs to make improvements. Importantly the provider should;

- Provide a clearer chronology of when complaints are responded to and when they are completed.
- Review refrigeration provision for busy periods of immunisations.

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 with some examples of very safe care and support for patients with a mental health diagnosis. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Good

The practice is rated as good for providing effective services with some clear examples of very effective care and treatment for patients diagnosed with a learning disability. Our findings at inspection showed systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing well when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Good

The practice is rated as good for providing caring services. Data showed patients rated the practice above many others for most aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they generally found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good

Summary of findings

facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice had a clear vision with quality and safety and teamwork as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a very high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

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. Nationally reported data showed outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. It was responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs.

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. 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 patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses particularly in regard of their "MAMA" clinic which provided a one stop shop for mothers with new children.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students). The needs of the working age population, those recently retired and students had

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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 reflected the needs for this age group.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of patients 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. It had carried out annual health checks for patients with a learning disability and all of these patients had received a follow-up appointment. It offered longer appointments for patients with a learning disability, provided questionnaires in advance of annual care reviews and worked closely with nursing teams to provide the best outcomes for this group of patients. Mental capacity assessments and Best interest decisions were routinely made for patients with a learning disability where required to ensure their safety.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. It had told vulnerable patients about how to access various support groups and local voluntary organisations. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of patients experiencing poor mental health (including patients with dementia). All patients experiencing poor mental health had received an annual physical health check. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. It carried out care planning for patients with dementia and worked closely to support their carers.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. Staff had received training about how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with 15 patients visiting the practice including two members of the patient participation group during our inspection. We received 13 comment cards from patients who visited the practice and saw the results of the last patient participation group survey. The practice shared their initial findings from their current 'friends and family' survey. We looked at the practices NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We looked at data provided in the most recent NHS GP patient survey (January 2015) and the Care Quality Commission's information management report about the practice.

The majority of comments made or written by patients were very positive and praised the care and treatment they received. For example; about receiving prompt treatment at times convenient to patients, about seeing a named GP where a preference was stated and about being involved in the care and treatment provided.

From the interviews we carried out we heard and saw patients generally found access to the practice and appointments easy and how telephones were answered after a brief wait. However, some comments made indicated it was not always easy to get through to the practice during the first hour of the practice opening. The most recent GP survey showed 55.2% of patients found it easy to get through to the practice by telephone compared to a Clinical Commissioning Group average of 78.6%. Patients told us they used the practices online booking systems to arrange or cancel appointments and to request repeat prescriptions or update their personal details.

Patients told us the practice was always kept clean and tidy and periodically it was refurbished and improved facilities added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and examination couches were covered with paper protective sheets. 89.4% of patients describe their overall experience of this practice as good.

We saw a range of thank you cards sent to GPs and nurses in the practice. These all thanked staff for their caring approach and their support at times of emotional need and ill health.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was sufficiently private for most discussions they needed to make. Patients told us about GPs supporting them at times of bereavement and providing extra support to young carers. A large number of patients had been attending the practice for many years and told us about how the practice had grown but they were always treated well. The GP survey showed 97.2% of patients said they had confidence and trust in the last GP they saw or spoke with, this increased to 100% for the nurses they saw.

Patients commented on the openness, accessibility and leadership of the practice, particularly the registered manager GP. Patient participation group members told us the partners and management staff engaged with them and encouraged their participation in decisions about improving the practice. They told us comments were listened to and improvements were made.

Areas for improvement

Action the service SHOULD take to improve

- Provide a clearer chronology of when complaints are responded to and when they are completed.
- Review refrigeration provision for busy periods of immunisations.

Summary of findings

Outstanding practice

We saw areas of outstanding practice:

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- Staff worked with social services and the police to ensure patient safety. We heard how staff supported a patient to go from the consulting room directly to an out of area refuge to ensure their safety. In another case where a plea for help was made, a patient and their children were taken directly from the practice to the police station to prevent further harm from a violent partner.
- In specific circumstances the practice continued to support patients who moved away from the practice area. A young patient diagnosed with an eating disorder who had continued to lose weight. A multi-agency decision was reached to detain this patient for their own protection under the mental health act legislation but the patient left the area. The patient wanted to remain with her GP and the practice agreed. The GP met the patient monthly. Records showed the patient slowly improved with their current BMI being considerably improved.
- The practice was a GP training practice and had three registrar GPs located at the practice at the time of the inspection. We saw one of the GPs who supported the registrar GPs had been awarded “Best GP year 5 trainer” for 2015. The registrar we spoke with commented on the high quality of support and mentoring provided within the practice.

Taunton Road 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 a variety of specialists including a practice manager and a practice nurse. We were accompanied by an Expert by Experience. Experts by Experience are a part of the inspection team and help with patient interviews; they are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Taunton Road Medical Centre

Taunton Road Medical Centre is located a short distance from the centre of Bridgwater, Somerset. The premises were purpose built with parking on site and level access into the building. The practice has approximately 14194 registered patients. The practice area is covered by a 6.5 mile radius of the practice and includes communities such as Cannington, Enmore, North Petherton, Westonzoyland, Chedzoy, Puriton and Pawlett. The practice works within Somerset Clinical Commissioning Group (CCG), which is responsible for the provision of health care throughout Somerset.

There are 11 GPs and a team of clinical staff including three independent nurse prescribers, five practice nurses, two health care assistants and a phlebotomist. Seven GPs are female and four are male, the hours contracted by GPs are equal to 8.38 whole time equivalent employees. Collectively the GPs provide 67 patient sessions each week in addition they provide extended hours for patients. Additionally the nurses and health care assistants employed equal to 6.96 and 2.02 whole time equivalent employees respectively. Non-clinical staff include secretaries, support staff and a small management team including a practice manager and practice assistant/ medical secretary.

The practice population ethnic profile is predominantly White British and with a range of affluent and deprived patients with an average in the mid-range of the Index of Multiple Deprivation profile. There is a practice age distribution of male and female patients' broadly equivalent to national average figures. There are about 0.2% of patients come from non-white ethnic groups. The average male life expectancy for the practice area is 80 years compared to the National average of 79 years; female life expectancy is 84 years compared to the National average of 83 years.

The National GP Patient Survey published in January 2015 indicated just over 81.7% of patients said they would recommend the practice to someone new to the area. This was slightly below the Clinical Commissioning Group average of 82.5%. Local Public Health statistics (January 2014) demonstrate Taunton Road Medical Centre population area had income deprivation levels for children and older patients similar to the national average; 22 and 20 compared to 22.5 and 22.5 respectively.

The practice has a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia and minor surgery services. It provides an influenza and pneumococcal immunisations enhanced service. These contracts act as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

Detailed findings

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Somerset Doctors Urgent Care (SDUC) and patients are directed to this service by the practice during out of hours.

Why we carried out this inspection

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

How we carried out this inspection

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

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

We 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 we hold about the practice and asked other organisations such as the Somerset Clinical Commissioning Group (CCG) and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 8 September 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included five GPs, a registrar GP, the lead nurse and three other nurses, a health care assistant, the practice manager and estates manager, and eight administrative and reception staff. We spoke with two members of the patient participation group, 13 patients and received comment cards from a further 13 patients.

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. These records showed the practice had managed safety consistently over time and could show evidence of a safe track record over the long term. The practice team met monthly with health visitors to discuss child protection and child in need concerns. A GP also attended a multi-agency risk assessment conference (MARAC) meeting in regard of concerns identified.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There was a "no blame" culture described by all staff we spoke with. They described how they shared significant events at clinical and nurse meetings and used the discussions and outcomes as springboard for improved practice. We reviewed records of 16 incidents considered as significant events which had occurred since January 2015 and saw this system was followed appropriately. Significant events was a standing item on the practice clinical meeting agenda, the nurses meetings and the communications meeting; 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. For example, the practice undertook an audit following a significant event analysis where no information had been received by the practice following a patient attending a two week wait appointment. The audit was completed and re-audited and the findings discussed within the federation and other practices undertook the same audit and the results have been shared with the Clinical Commissioning Group to help improve systems and outcomes. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet to report significant events or incidents and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked four incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example, changing the emergency medicines trolley to a system of “grab bags” in support of incidents in external locations such as the car park. However we noted the significant event log did not show the time line for responses in the same way as the main reporting forms. This made gaining a quick oversight of how all significant events were responded to difficult and highlighted this to the practice manager. They arranged to update the log. Where patients had been affected by something which had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the practice manager and premises manager to practice staff. Staff we spoke with were able to give examples of recent alerts which were relevant to the care they were responsible for. They told us alerts were discussed at clinical, nursing and administrative meetings to ensure all staff were aware of any which were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young patients and adults. We looked at training records which showed all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

Good

Are services safe?

The practice had appointed dedicated GPs with lead responsibility for safeguarding vulnerable adults and children. Information about who these staff were was displayed in the staff reception area. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans or adults living in vulnerable circumstances. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

We noted there was very useful and informative information on the practices website and in the practice for patients about vulnerable patients, domestic violence and abuse. Information included, raising concerns, types of abuse and indications of abuse. The information explained abuse could affect young or elderly patients, those with mental health issues, physical disabilities, learning disabilities or gender. They highlighted individuals could be at risk because they were socially isolated or were dependent on others such as a carer. Additional information in the practice included information about domestic violence and abuse.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms and on the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). The chaperone information for patients was presented in two alternative languages; Polish and Portuguese to better inform patients. All nursing staff and GPs had been trained to be a chaperone, were Disclosure and Barring Service (DBS) checked and routinely stepped in to support patients when needed.

GPs and nurses were appropriately using required codes on their electronic patient record system to ensure risks to children and young patients who were looked after or who had child protection plans were clearly indicated and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police and social services. Staff were proactive in monitoring if children, patients with a diagnosed learning disability or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals. We saw minutes of monthly multi-disciplinary team meetings where vulnerable patients' needs and circumstances were discussed.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed temperature checks were carried out which ensured medicines were stored at the appropriate temperature. The practice used additional fridges to store vaccinations at peak period, for example during flu vaccination periods. We noted not all fridges used were medicines specification but were kept in lockable rooms and stock could be accounted for. We highlighted this to the practice manager and registered manager who responded positively and stated they would replace the fridges with medicine refrigerators.

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

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

We saw records of practice clinical and nurses meetings which noted the actions taken in response to a review of prescribing data. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other

disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We noted a safe system for managing prescriptions for rehabilitation medicines such as methadone. The prescription was sent electronically to the patients preferred pharmacist to reduce the risk of loss or misappropriation. Where patients alleged medicines were lost or stolen they were required to provide a police crime reference number before GPs would consider re-prescribing. This approach had significantly reduced the need for re-prescribing of these medicines.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs had been updated in the last few weeks. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) which had been produced by the prescriber. We saw evidence nurses and health care assistants had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. Three members of the nursing staff were qualified as independent prescribers and they received regular supervision and support in their roles as well as updates in the specific clinical areas of expertise for which they prescribed.

The practice had established a service for patients to pick up their dispensed prescriptions at their chosen locations and had systems in place to monitor how these medicines were collected. They had arrangements in place to ensure patients collecting medicines from these locations were given all the relevant information they required. The pharmacist in the adjacent pharmacy confirmed these arrangements were in place and noted the supportive nature of practice staff in ensuring medicines safety.

The lead prescribing GP worked with a Pharmacist from the Clinical Commissioning Group to improve medicines management in residential and care homes.

Cleanliness and infection control

We observed the premises to be clean and tidy and saw the practice employed cleaners throughout the day to ensure hygiene standards were maintained. We saw there were cleaning schedules in place and cleaning records were kept. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

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

The practice had two nurses with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence the nurses had carried out audits for each of the last two years and any improvements identified for action were completed on time. Minutes of practice meetings and action plans showed the findings of the audits were discussed.

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

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. The last Legionella check was carried out on 4 September 2015 and we saw these checks were carried out weekly.

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 and we saw equipment maintenance

Good

Are services safe?

logs and other records confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was July 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices, fridge thermometers and emergency and fire equipment.

Staffing and recruitment

The practice had a clear recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure enough staff were 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. The practice manager showed us records to demonstrate actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. The practice employed an IT and estates manager to oversee many of these systems. These included regular checks of the building, the environment, medicines management and they reported their findings to the practice manager. Emergency medical equipment and medicines were checked by the nursing leads. The practice had a health and safety policy. Health and safety information was displayed for staff to see and there were identified health and safety representatives; we noted training updates had not been undertaken recently for staff in this role.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, during our inspection a patient became unwell with the member of staff requiring assistance to support the patient. We saw how staff responded promptly and professionally to the request for assistance and the patient responded positively to the care and treatment provided. We saw there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly.

Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment via the local crisis team. The practice monitored repeat prescribing for patients receiving medicines for mental ill-health (93 patients) and those experiencing drug and alcohol problems (358 patients) as well as for patients diagnosed with long-term conditions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed it was checked regularly. We checked the pads for the automated external defibrillator were within their expiry date; these were due to expire at the end of September 2015 and we were provided with evidence that new pads had been ordered.

Good

Are services safe?

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

A business continuity plan was in place to deal with a range of emergencies 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 document included relevant contact details for staff to refer to. For example, contact details of utility companies to contact if the heating, lighting or water systems failed. The plan was last reviewed in July 2015 and copies were held off site by the practice manager and partners.

The practice had carried out a fire risk assessment in February 2013 which included actions required to maintain fire safety. The policy was reviewed every 5 years. Records showed staff were up to date with fire training and they practised regular fire drills. The most recent fire evacuation was carried out in September 2015.

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 guidance from local commissioners was readily accessible in all the clinical and consulting rooms via online systems and journals. We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website or received via emails and disseminated to staff. We saw minutes of clinical meetings which showed the information was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. For example, NICE care pathways for type 2 diabetes. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required. A specialist diabetic nurse visited patients at home to undertake their birthday review if they were unable to attend surgery.

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

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

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

Management, monitoring and improving outcomes for people

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

The practice showed us a small sample of the 25 clinical audits undertaken in the last two years. Most of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, for patients receiving testosterone replacement who should have had blood test monitoring at three, six, and 12 months. The initial audit showed only 35% of the sample group had received the required monitoring. The practice introduced a number of actions including setting up recall appointments and adding system alerts. A second audit showed an increase in monitoring being carried out with 77% having had the required blood tests. Further actions were being carried out to improve outcomes for these patients. Other examples included audits to confirm fast track referrals were being carried out in accordance with local guidance and prescribing rates for medicines such as antibiotics.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the quality and outcomes framework (QOF). (QOF is a voluntary incentive scheme for

Good

Are services effective?

(for example, treatment is effective)

GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory medicines. Following the audit, the GPs carried out medicines reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. Clinical audit findings were shared at the monthly clinical meetings. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice was aware of all the areas where performance was not in line with national or Somerset Clinical Commissioning Group (SCCG) figures; however we saw action plans setting out how these were being addressed. This included the practice manager overseeing QOF performance and giving all GPs and lead nurses an area which they had lead responsibility for. The practice manager liaised with the leads if an area was not performing as it should.

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

The practice's prescribing rates were similar to national figures for hypnotics, antibacterial prescribing, non-steroidal anti-inflammatory medicine item prescribing and antibiotic items prescribing. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. Additionally they checked all routine health checks were completed for long-term conditions such as diabetes and the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had made use of the gold standards framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice had recognised the needs of carers for patients in this group and provided additional carer information to carers.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups including patients with a learning disability and those with drug and alcohol problems. Structured annual reviews were undertaken for patients with long-term conditions for example, those patients diagnosed with diabetes, chronic obstructive pulmonary disease (COPD), asthma, coronary heart disease, atrial fibrillation, epilepsy, hyperthyroidism, mental health, chronic kidney disease and heart failure. We were shown data that 100% of these reviews had been carried out in the last year.

The practice participated in local benchmarking run by the CCG. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. The benchmarking data showed the practice had outcomes which were comparable to other services in the area. For example, for prescribing hypoglycaemic agents and other medicines. They made regular use of ABACUS data to benchmark practice performance in regard of hospital admissions and minor injuries unit attendance. We saw the information was discussed by the practice to account for admissions and attendances and to develop ways to reduce patient attendances to both services.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw all staff were up to date with attending core skills courses such as annual basic life support, fire training, infection control, health and safety, manual handling and safeguarding. We noted a good skill mix among the doctors with three having additional diplomas in sexual and reproductive medicine, two with diplomas in children's health and obstetrics and three with diplomas in surgery. Other GP interests included, ultrasonography, supporting patients with learning difficulties, training (registrars, specialty trainees, fourth and fifth year medical students), pain management and diabetes.

Good

Are services effective?

(for example, treatment is effective)

All GPs were registered and up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example, diabetes management, medicines prescribing and managing challenging behaviour. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, for the administration of vaccines, cervical cytology and diabetes management. Those with extended roles for seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), and coronary heart disease were able to demonstrate they had appropriate training to fulfil these roles.

Staff files we reviewed showed where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well.

Emergency hospital admission rates for the practice were relatively low at 5.64% compared to the national average of 7.4%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw the policy for actioning hospital communications was working well in this respect. The practice undertook a yearly audit of follow-up appointments to ensure inappropriate follow-ups were documented and no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long-term conditions, mental health problems, patients from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, the learning disability nurse, palliative care nurses and decisions about care planning were documented in a shared care record. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

We noted particularly positive working relationships with the community specialist learning disabilities nurse. They attended regular meetings with the practice to act as a link worker for the 99 patients the practice supported who had a learning disability. We spoke with the nurse during our inspection and heard how their role included liaising with the practice on a range of learning disability issues. This extended from revalidating the learning disability patient register annually, discussing how best to facilitate the yearly health checks to meeting with GP partners and other practice staff to discuss some of the prevalent issues the practice had in their support of patients in this group. Additionally the community learning disability nurse, the lead GP for the practice for learning disabilities and the practice manager met with two care homes for this group of patients, to work out the best way of joined up working between the practice and the home for the benefit of the patients.

Good

Are services effective?

(for example, treatment is effective)

We heard about patient specific examples of involvement and input into mental capacity decisions from a visiting community learning disability nurse and how in partnership with GPs they ensured the best patient outcome in the circumstances. The community learning disability nurse attended meetings with the practice and care homes to discuss issues and worked collaboratively to help improve the care for patients. The nurse worked with the practices GP with lead responsibilities for learning disabilities to ensure reasonable adjustment interventions were made for patients including appointment times most suited to the patient and creating the right environment for the appointment.

These involvements helped ensure successful access to primary care services for these patients. For example, an anxious patient requiring regular leg ulcer dressings became agitated when dressings were applied by the community nurse and would remove them almost immediately. The practice staff worked with the learning disability nurse to create an environment the patient was more comfortable with. They engaged one of the practice nurses who had a good rapport with the patient, they were able to apply the dressings with the patient's cooperation and the patient did not remove them. The outcome for the patient was positive.

We heard how practice staff worked with carers and family members of patients with learning disabilities. Prior to appointments or annual reviews the practice sent them out forms in advance to enable them to fill in some information which helped provide more time during the appointment to focus on the patients' needs.

Another of the GP partners along with three other practice GPs had been trained to provide regular weekly appointments at a local secure forensic psychiatric institution for patients with psychiatric conditions. The GPs focused on supporting the patients with their general health needs and were able to work flexibly if other support was required. Feedback about the practices involvement from one of the services consultants was very positive with comments about patients being supported to maintain good health enabling them to work towards improved mental health. The practice and consultants met annually to review patient care and treatment to ensure quality of service was maintained and improved for patients.

We were provided with information demonstrating how practice staff worked with other agencies to support patients who were victims of domestic violence. We heard examples of where staff worked with social services and the police to ensure patient safety. For example, working with other agencies to gain access to an out of area refuge to ensure their safety and ensuring patients could get safely to the police station to prevent further harm from a violent partner. The GP involved attended a multi-agency risk assessment conference (MARAC) meeting concerning this case.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP Out-of-Hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had signed up to the electronic Summary Care Record which was fully operational by early 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Templates were utilised within the clinical system, linking them with National Institute for Health and Care Excellence (NICE) guidance to ensure consistency of recording to help to improve patient outcomes. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence that on-going audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the

practice had drawn up a policy to help staff. For example, with making decisions about minor surgical treatment. The policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. We saw 100% of care plans had been reviewed in last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. We were shown numerous examples of best interest decisions recorded in patients' records which evidenced clear decision making pathways. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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

Health promotion and prevention

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

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and sign posting patients to smoking cessation advice services if identified as a smoker. Patients attending chlamydia screening were given information about the MEN AWCY vaccine (The Men ACWY vaccine protects against four types of meningitis).

The practice had many ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, mechanisms of identifying 'at risk' groups were used for patients who were obese. The practice had identified 412 patients in this category and supported them to access services and groups to help manage or reduce their weight. In addition the practice identified 36 patients requiring palliative care and ensured those receiving end of life care received support in a timely way. Twenty five of the practices patients were supported through 'Tele health' monitoring, this benefitted patients through not having to travel to the practice for appointments. (Telehealth is the delivery of health-related services and information via telephone or internet technologies). These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 80.53%, which was similar to the national average of 81.88%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example;

- Flu vaccination rates for the over 65s were 72.44%, and at risk groups 46%. These were similar to national averages and were often carried out in patients homes.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 91.2% to 100% and five year olds from 87% to 97.8%. These were comparable to CCG averages.

Good

Are services effective?

(for example, treatment is effective)

GPs and nurses in the practice had access to a searchable intranet. We saw an example of looking at cow's milk allergies following a suspicion that cow's milk protein allergy (CMPA) might have been a cause of the young patients' problems. We heard how reduce and reintroduction advice was provided to the mother and how improvements were noted. Alongside this we saw effective use of evidence based medicine sources and resources to tailor care to patient needs. Where these resources were used it was noted in patient records.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January 2015, a survey of patients undertaken by the practice's patient participation group (PPG) and NHS Friends and Families questionnaires completed by patients. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'In the middle range' for patients who rated the practice as good or very good. The practice was also slightly above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 94.4% of patients said the GP was good at listening to them compared to the Clinical Commissioning Group (CCG) average of 91.6% and national average of 88.6%.
- 90.3% of patients said the GP gave them enough time compared to the CCG average of 89.8% and national average of 86.8%.
- 97.2% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95.3%
- 100% of patients said they had confidence and trust in the last Nurse they saw compared to the CCG average of 98.3% and national average of 97.2%

Patients completed CQC comment cards to tell us what they thought about the practice. We received 13 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with 15 patients on the day of our inspection. All told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw how staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk and was in a separate area which helped keep patient information private. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This helped prevent patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained. Additionally, 87% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 86.9%.

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

Patients whose circumstances may make them vulnerable and those experiencing poor mental health were able to access the practice without fear of stigma or prejudice. Staff treated patients from these groups in a sensitive manner. Training was available online to staff about how to deal sympathetically with all groups of patients and staff had access to additional training about challenging behaviour. The reception staff we spoke with had completed this additional learning and stated they found it helpful when managing difficult situations.

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:

- 92% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90.1% and national average of 86.3%.

Good

Are services caring?

- 86.8% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86.1% and national average of 81.5%.

Patients we spoke with on the day of our inspection told us their health issues were discussed with them and they felt involved in decision making about the care and treatment they received. We heard how nurses discussed care plans with patients, gained their views and updated the care plan with the patient. A printed copy of the care plan was then provided to the patient. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was positive and aligned with these views.

Staff told us translation services were available for patients who did not have English as a first language. We saw information in the reception area informing patents this service was available. We heard from staff how they had access to patient information sheets online which were available in a range of languages. These were printed out for patients when needed.

We saw evidence of care plans for older patients and patient involvement in agreeing these. Where relevant the care plans included information about end of life planning and were signed by patients. Patients with diagnosed long-term conditions who were identified as being at risk of hospital admission had care plans and we saw evidence patients' were involved in agreeing to the plan of actions. There were 226 patients on the practices admission avoidance register; care plans were in place for the most at risk patients.

We saw families, children and young patients were treated in an age-appropriate way and children were recognised as individuals with their preferences considered. We observed nurses greeting children directly and by their chosen name.

Patient/carer support to cope emotionally with care and treatment

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

- 92.2% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.9% and national average of 85.1%.
- 98% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. For example, these highlighted how staff responded compassionately when they needed help and provided support when required. One of the staff had lead responsibility for carers and we saw carer information displayed in the waiting area as well as information about counselling and bereavement support.

Notices in the patient waiting room, on the TV screen and patient website informed patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. This included referrals to Compass Care, a local support group and counselling service.

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

The practice recognised isolation as a risk factor for vulnerable and elderly patients and sought to support patients to address this through referrals to other organisations and support groups. Patients with long-term conditions and multi-morbidities were supported by the practice through the provision of 'birthday reviews' of their conditions and medicines in addition to their routine appointments. The practice encouraged self-referral to a 'Talking Therapies' counsellor where anxiety and depression were identified. Where the patient chose, the practice would make a referral on their behalf.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, through extended opening hours, longer patient appointments where needed and providing seasonal vaccination clinics at weekends.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements which needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, through health promotion scheme referrals to dieticians, physiotherapists and counsellors.

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

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). For example, monitoring telephone demand and providing additional resources to manage demand, promoting online access to appointments, repeat prescribing and patient information and encouraging better appointment attendance by patients. Following patient feedback the practice introduced an 'express counter' service. This counter was available at peak times to deal with simple quick items of concern or need raised by patients.

In specific circumstances the practice continued to support patients who moved away from the practice area. For example, a young patient diagnosed with an eating disorder who had been referred to Somerset eating disorders group by one of the GP due to stresses related triggers. They had continued to lose weight and the group were worried about them. They made a decision to section the patient under the provision of the Mental Health Act 2015 due to their lack of insight into their health. The patient left the area before this happened, however, the patient wanted to remain with their GP due to their good relationship and support. The practice agreed to the patient remaining with them and the GP met them monthly. Records showed the patient slowly improved with their current BMI being considerably improved. The frequency of visits had reduced and they had managed to get through further life stresses without weight loss. Another example included a patient who frequently called the 111 service and the practice. The practice thought of ways of how best to address the patient's needs resulting in the patient seeing one of the nurse practitioners weekly. This approach reduced patient demand on the 111 service and improved patient care.

Tackling inequity and promoting equality

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

The practice made changes to become dementia friendly following training undertaken by practice staff. Changes included improved lighting and signage. These changes included lighting in the GP corridors and signage on the toilet doors. The premises and services had been designed to meet the needs of patients with disabilities. The practice was accessible to patients with mobility difficulties; an accessible lift was available to access services on the first floor. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. Our expert by experience noted the hand dryer in one accessible toilet was too high for wheelchair users and we raised this with the practice manager so they could review facilities in this

Good

Are services responsive to people's needs?

(for example, to feedback?)

area. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us patients who were of "no fixed abode" could see someone if they came to the practice. The practice would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The practice was open from 7:45am to 6:00pm Monday to Friday with telephone assistance available until 6:30pm. GP and nurse appointments were available from 7:45 am on weekdays. Later telephone appointments were available between Monday and Thursday. If a face to face consultation needed to be arranged this would be carried out between the patient and their usual GP. The duty doctor was available from 8:00am until 6:30pm each weekday. The practice operated an emergency only call system between 12:30pm and 1:30pm. Acutely ill children were booked directly with a nurse practitioner or a GP on the day. The reception team had a flow chart of booking for on the day patient care.

The practice operated a duty team system in conjunction with other staff to provide on the day care. Minor illness requests were passed directly to a nurse practitioner for them to determine the most appropriate course of treatment. Requests to speak with a GP led to GPs calling patients back within an hour which could result in them being provided with advice or a same day appointment. Appointments could be pre-booked with nurses and health care assistants. The Practice offered a phlebotomy service all day including early morning appointments provided electro cardiographs, spirometry, 24 hour blood pressure monitoring, International Normalisation Ratio (INR) testing (anti-coagulant monitoring), minor surgery, contraceptive services (including coil and implants) and insulin initiation.

Each day the practice held informal coffee/tea meetings at 11am and 4pm. The GPs used these meetings to review session appointments, discuss issues which had occurred with patients, plan for upcoming appointments and to plan who was best skilled to visit individual patients requiring home visits. A large screen linked to the patient record system was used to review each patient's needs; we saw how the visits were allocated based on patient needs and GPs specialist skill areas.

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

Longer appointments were available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. These included some appointments with a named GP or nurse where requested. Home visits were made to nine local residential and nursing homes and ten homes for patients with learning disabilities. A named GP carried out these visits. Home visits were provided to those patients who needed one including visits by a nurse for elderly patients who could not attend the practice for annual birthday reviews.

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

- 80.5% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 77.2% and national average of 75.7%.
- 74.1% of patients described their experience of making an appointment as good compared to the CCG average of 79.2% and national average of 73.8%. However, some comments made by patients we spoke with indicated it was not always easy to get through to the practice during the first hour of the practice opening.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 73.4% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70.1% and national average of 65.2%.
- 55.2% of patients said they could get through easily to the practice by phone compared to the CCG average of 78.6% and national average of 74.4%.

Patients we spoke with were generally satisfied with the appointments system and said it was easy to use. They confirmed they could see a doctor on the same day if they felt their need was urgent although this usually might not be with their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking up to 12 weeks in advance. Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, where a child had become unwell, if a dressing required replacement or where health conditions had deteriorated

Appointments were available outside of school hours for children and young patients. We noted the premises were suitable for children and younger patients and there was confidential access to sexual health clinics and sexual health advice. The practice understood the local student population and working age patients and their services reflected this through extended opening hours. There was an online booking system available which was easy to use and telephone consultations where appropriate. Patients were supported to return to work through the 'Fit note' scheme and could self-refer to counselling service such as 'Talking therapies'. (GPs issue fit notes to patients to provide evidence of the advice they have given about their fitness for work to help them return to work).

Partnership working was a priority for the practice to help them understand the needs of the most vulnerable in the practice population as well as patients with mental health concerns. They worked closely with community service, specialist services such as mental health support groups, drug and alcohol services and the learning disability team. Longer appointments were available for those who need them and flexible services and appointments were available including for example, avoiding booking appointments at busy times for patients who may find this stressful.

Listening and learning from concerns and complaints

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

We saw information was available to help patients understand the complaints system for example, information displayed in the waiting/reception area, practice leaflet and on their website. Patients we spoke with were broadly aware of the process to follow if they wished to make a complaint; with most saying they would approach the receptionists. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at the log of the complaints received in the last year and looked in detail at a small sample from the complaints file. We found complaints were satisfactorily handled, dealt with and there was an openness and transparency when dealing with the concerns raised. We noted the log included handling informal verbal complaints thoroughly alongside written complaints. We noted aspects of the process which could be improved for example, a clearer chronology of when the complaint was responded to and when it was completed.

The practice reviewed complaints monthly at clinical meetings to ensure actions had been carried out in line with policies. We looked at the minutes and the complaints log where themes had been identified. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. For example, responding to phone calls more positively, providing customer care training for reception staff and providing patients with more information about the duty and appointment systems.

We saw minutes of team meetings showing complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action which might be required. There was evidence of shared learning from complaints with staff and other stakeholders.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and 2015 business plan. We saw evidence the strategy and business plan were regularly reviewed by the practice. The practice vision and values included; teamwork, patient centred care and treatment, providing a range of accessible appointments, being responsive and caring, ensuring quality and safety and anticipating patients needs and supporting them through care planning.

All the members of staff we spoke with during our inspection knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the practice away day held in March 2015 and saw staff had discussed the vision and values. We noted throughout our inspection how teamwork was a common thread for all staff.

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 and in files in staff areas. We looked at 12 of these policies and procedures, most staff confirmed they had read the policies either when they commenced work at the practice or when the policy had been updated. All 12 policies and procedures we looked at had been reviewed annually and were up to date.

There was a clear leadership structure with named members of staff in lead roles. For example, there was a lead nurse for infection control and four of the partners had lead responsibility for safeguarding adults and children. All members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt highly valued, well supported and knew who to go to in the practice with any concerns.

The GPs, nurses and practice manager took an active leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The QOF data for this practice showed it was performing in line with national standards. We saw QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, making changes to medicine prescribing, enhancing support of patients with hypertension and improving record keeping to support continuity of patient care. Evidence from other data from sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example, in changing the way emergency treatment was provided if a patient became unwell in the practice. The practice monitored risks monthly to identify any areas which needed addressing.

The practice held monthly clinical meetings where governance issues were discussed. We looked at minutes from these meetings and found performance, quality and risks had been discussed. A separate quarterly governance meeting was scheduled with the last meeting being held in March 2015. The June meeting had been postponed for operational meetings and the next one was due in late September. As part of their overall governance arrangements a range of other meeting were held each month including, partners meetings, communication meetings, team meetings and patient participation group meetings. In addition there were two away-day mornings each year and annual appraisals for all staff which helped facilitate feedback from staff about practice performance against their vision and strategy.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies

Are services well-led?

Good

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

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

To ensure all new GPs, registrars, nurses and locum staff understood the practices governance arrangements the practice had produced a detailed booklet. The booklet clearly explained the staff structure of the practice, outlined the range of services provided, contained key policy and contact information and informed them about the core operational principles of the practice. Feedback from staff who had been provided with this booklet was positive.

Leadership, openness and transparency

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

We saw from minutes that team meetings were held every month. Nurse prescribers were supported by GPs through monthly tutorials and the lead GP for the nursing team attended monthly nurse meetings providing clinical updates to the nursing team. Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We heard how the practice operated an open door policy for any clinician or other member of the team to seek help or advice from another clinician. We noted team away days were held every six months. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

In support of team building and teamwork the practice encouraged staff to be involved in activities outside of the practice and working day. We saw how staff had been involved in charity running events representing the practice as well as dragon boat racing and participating in a sports day for patients and staff organised in conjunction with other practices in the federation. We heard of examples of how the leaders in conjunction with the staff team organised decorating parties to help improve the practice environment, deep cleaned consulting rooms to improve hygiene standards and helped clean a basement area following a flood. All staff commented positively about the openness and transparency the leadership displayed.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. It had an active PPG which included representatives from various population groups such as, older patients, those with long term conditions and the working population. The PPG had carried out annual surveys and met every quarter; subjects discussed included, international normalised ratio (INR) clinics, maternity and mums (MAMA) clinic, why patients fail to attend their appointments promoting the cancellation line and on line access. (The MAMA clinic allowed new mothers and their baby to attend one 30 minute appointment for the post-natal check and the first set of childhood immunisations. The appointment was with a practice nurse and a GP). The discussions led to improved services for patients.

The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We saw evidence the practice had reviewed its' results from the national GP survey to see if there were any areas which needed addressing. Patients were encouraged to provide feedback through the surveys, Friends and Families questionnaire and via the practices website. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice through the PPG. The PPG representatives we spoke with confirmed the practice was actively engaged with the group and encouraged their participation in all aspects of practice improvement.

Are services well-led?

Good

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

The practice had gathered feedback from staff through annual staff survey, through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us they had asked for specific training around diabetes at the staff away day and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at six staff files and saw regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff away days where guest speakers and trainers attended. We saw this was enhanced by additional learning sessions at clinical meetings.

The practice was a GP training practice and had three registrar GPs located at the practice at the time of the inspection. The registrar GPs started at the practice three weeks prior to the inspection and were aware there were three of the practices GPs providing support to the registrar GPs. The registrar GP we spoke with told us prior to joining the practice they were aware of their excellent reputation. We saw one of the GPs who supported the registrar GPs had been awarded “Best GP year 5 trainer” for 2015. The registrar told us they felt they received excellent support from the leadership team and found the practice manager very knowledgeable and superbly organised providing regular communication bulletins which helped to update everyone.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, ensuring patient record updates were carried out correctly, providing additional training for reception staff and working with the police to ensure the environment of the practice was safe.