Dr B Newmarch and Partner

Quality Report

Victoria Gate Surgery
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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 Victoria Gate Surgery on 8 May 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for patients with long term conditions, families, children and young people, working age people (including those recently retired and students), people whose circumstances may make them vulnerable and people experiencing poor mental health (including people with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect by all staff and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent and triage appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- 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:

Summary of findings

- The practice had identified an issue caused by some patients repeatedly losing or claiming their prescriptions had been stolen. To address this issue the practice met with staff from the local homeless hostel and the police to develop a strategy to manage the problem. This approach had considerably reduced the incidents of claimed lost or stolen prescriptions.
- All patients had access to 15 minute appointments, with longer appointments available for those that required more time. Patients with a learning disability had their medicines reviewed at least three times a year and more often if they had complex needs. The Somerset drug and alcohol service provided appointments once a fortnight for vulnerable patients in conjunction with GPs in the practice.
- The practice had developed an innovative approach to support vulnerable patients with chaotic lifestyles who required Med 3 sick notes to access benefits. They had identified lost sick notes caused delays in accessing benefits which subsequently impacted on patients' health. The practice established an arrangement with the Department of Work and Pensions (DWP) whereby the sick notes were emailed directly to the DWP.

However there was an area of practice where the provider could make improvements.

Importantly the provider should

- Review the process for recording legionella testing.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

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

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 found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet their

Summary of findings

needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

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

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered

Summary of findings

to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and the majority of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

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

People experiencing poor mental health (including people with dementia)

Good

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

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

Summary of findings

What people who use the service say

We spoke with four patients visiting the practice during our inspection, three members of the patient participation group and received 31 comment cards from patients who visited the practice. We saw the results of the last Patient Participation Group report dated March 2015. The practice also shared their initial findings from their current 'friends and family' survey. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent National GP patient survey published on 8 January 2015 and the Care Quality Commission's information management report about the practice.

All comments from patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving good care and treatment, about seeing the same GP when requested and about being treated with respect, compassion and consideration. Other comments included statements of how responsive the practice was in providing appointments and responding to concerns and receiving an apology.

We heard and saw how patients found access to the practice and appointments easy and how telephones were answered after a brief period of waiting. Comments from the National GP Patient Survey indicated 98% of patients saying it was easy to get through by telephone.

The most recent GP survey showed 98% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online booking systems to get appointments.

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

Patients told us the practice was always kept clean and tidy and periodically it was refurbished. Patients also told us improved repeat prescription facilities had been added which made the process easier to use. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. Information from the National GP Patient Survey showed 93% of patients described their overall experience of this practice as good.

Areas for improvement

Action the service SHOULD take to improve

- Review the process for recording legionella testing.

Outstanding practice

- The practice had identified an issue caused by some patients repeatedly losing or claiming their prescriptions had been stolen. To address this issue the practice met with staff from the local homeless hostel and the police to develop a strategy to manage the problem. This approach had considerably reduced the incidents of claimed lost or stolen prescriptions.

Summary of findings

- All patients had access to 15 minute appointments, with longer appointments available for those that required more time. Patients with a learning disability had their medicines reviewed at least three times a year and more often if they had complex needs. The Somerset drug and alcohol service provided appointments once a fortnight for vulnerable patients in conjunction with GPs in the practice.
- The practice had developed an innovative approach to support vulnerable patients with chaotic lifestyles who required Med 3 sick notes to access benefits. They had identified lost sick notes caused delays in accessing benefits which subsequently impacted on patients' health. The practice established an arrangement with the Department of Work and Pensions (DWP) whereby the sick notes were emailed directly to the DWP.

Dr B Newmarch and Partner

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP and a practice nurse.

Background to Dr B Newmarch and Partner

Dr B Newmarch and Partner, Victoria Gate Surgery, East Reach, Taunton, Somerset. TA1 3EX is located close to the centre of Taunton. The premises are purpose built. The practice has approximately 4,250 registered patients and has seen a growth in the patient list of about 5% annually. The practice accepts patients from an area from Eastwick and Selworthy Road to the North, Ruishton to the East, Killams to the South and Mary Street and Station Road to the West.

The practice has very recently merged with another local practice and was in the process of re-registering with the Care Quality Commission. It is currently proposed that the two practices will retain independent patient lists but will make many aspects of their services available to both groups of patients.

There are four salaried GPs and a team of clinical staff including practice nurses and a health care assistant. Three GPs are female and one is male, the hours contracted by GPs are equal to 2.55 whole time equivalent employees. Collectively the GPs provide 22 patient sessions each week. Additionally there are two nurses employed equal to 1.4 whole time equivalent employees and a health care assistant equal to .56 whole time equivalent employees employed. Non-clinical staff included secretaries, IT staff, support staff and a small management team including a practice manager. A practice pharmacist employed by the Clinical Commissioning Group supports the practice one day a week.

The practice population ethnic profile is predominantly White British with an age distribution of male and female patients' equivalent to national average figures. There are about 28% of patients from Other White ethnic groups, the majority being patients from Poland The average male and female life expectancy for the practice is 80 and 84 years respectively, both figures are very slightly above the national average. The National GP Patient Survey published in January 2015 indicated 78% of patients said they would recommend the practice to someone new to the area. This was slightly below the Somerset Clinical Commissioning Group average of 83%. Most patients attending the practice live in urban populations with about 60% of patients living in the Halcon estate which is the second most deprived area of Somerset. The practice directly supports patients from nine learning disability homes and a large 60 place hostel for homeless people and has an enhanced contract for supporting violent patients in the Taunton and Wellington area.

The practice has a Personal Medical Services (PMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, online access and diabetes services. It also provides a drug misuse shared care enhanced service. These contracts act as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

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

Detailed findings

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Somerset Clinical Commissioning Group 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 May 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included two GPs, one practice nurse, the practice manager and four administrative and reception staff. We spoke with three members of the patient participation group, four patients and received comment cards from a further 31 patients.

Good

Are services safe?

Our findings

Safe track record

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

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 15 months. These showed the practice had managed them consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last 15 months and we were able to review these. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held monthly to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. The practice manager showed us the system used to manage and monitor incidents. We tracked seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, a results protocol was updated and an additional patient records audit was carried out following an incident involving a locum GP. Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the practice manager by email to practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts for example, new antibiotic formulary from medicines management, were discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that 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 people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice had appointed a dedicated GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary training to enable them to fulfil this role. All staff we spoke with were aware who the lead was 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 where there were concerns about adults living at the same location as a potentially vulnerable child.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including the health care assistant, had been trained to be a chaperone, including where to stand to be able to discretely observe the examination.

Medicines management

Good

Are services safe?

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. Each was on a separate electrical circuit to ensure backup storage was available if one circuit failed. There was a clear policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

We saw records of practice meetings that 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.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. Where the health care assistant administered vaccines such as influenza vaccinations these were carried out in conjunction with patient specific directions which were signed by the GP. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

There was a system in place for the management of high risk medicines, which included regular monitoring in line with national guidance. Appropriate action was taken based on the results. We checked anonymised patient records which confirmed that the procedure was being followed.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice had identified an issue caused by some patients repeatedly losing or claiming their prescriptions had been stolen. To address this issue the practice met with staff from the local homeless hostel and the police to develop a strategy to manage the problem. The outcome of the meeting was all prescriptions for hostel residents would be collected by staff on the residents' behalf. If a patient lost a prescription, the surgery would not reprint it until it is next due. If a patient has a prescription stolen, they must report it stolen to the Police, the Taunton Town Centre team would be alerted and they would take a statement from the patient. A crime reference number would be generated. A member of the Taunton Town Centre team would then inform the surgery that this has happened. The surgery would only reprint a prescription on receipt of a crime reference number. This approach had considerably reduced the incidents of claimed lost or stolen prescriptions.

Cleanliness and infection control

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

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

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, when carrying out intimate examinations or minor surgery. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury. Entries in the practices accident log confirmed this.

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

The practice had a risk assessment for the management, testing and investigation of legionella (a bacterium that can

grow in contaminated water and can be potentially fatal). We saw records which confirmed the practice last had their water system checked in March 2015 and temperatures were calibrated to the required levels. An external contractor had been booked to carry out a full legionella check and was expected before August 2015. However we noted the practice did not have records to indicate regular checks of the system had been carried out. The practice manager arranged for appropriate records to be implemented once this was highlighted to them.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. The last recalibration took place on 24 March 2015 and annually previously. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, ultrasound, cautery, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

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 criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared the recent findings from an infection control audit with the team.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions and for identifying acutely ill children. 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 or support from local psychiatric services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. The notes of the practice's significant event meetings showed that staff had discussed a medical emergency concerning a patient and that practice had learned from this appropriately.

Emergency medicines were available in a secure area of the practice and all staff knew of their location. These included those for the treatment of conditions such as cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use, this was

Good

Are services safe?

recorded weekly. We noted historical gaps in recording these checks but saw this had been recognised by the practice and had been discussed at one of the practice meetings All the emergency medicines and equipment we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of utility companies to contact if the heating, lighting or water systems failed.

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

Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the practice risk log. We saw an example of this and the mitigating actions that had been put in place to manage this.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners through the practices 'Pathway Navigator' system. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses and the records we viewed, that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as dermatology, asthma and chronic obstructive pulmonary disease (COPD) and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to continually review and discuss new best practice guidelines, an example was for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The senior GP partner showed us data from the local Taunton Deane Federation of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients with high blood pressure which showed all were receiving appropriate treatment and regular review. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients recently discharged from hospital, which required patients to be reviewed within one week by their GP according to need.

National data showed that the practice was slightly above local referral rates to secondary and other community care services for some conditions. This was accounted for by the higher levels of deprivation, homelessness and drug misuse in the area.

All GPs we spoke with used national standards for the referral of patients with suspected cancers referred and seen within two weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

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. This was particularly apparent for homeless people in the area requesting GP service; the practice supported these people to become patients of the practice. We observed positive interactions for one person in this group and saw they were registered and saw a GP during our inspection.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits.

The practice showed us 11 clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, ensuring patients prescribed antipsychotic medicines had a medicines review and a cardiovascular disease risk assessment at least annually. Other examples included audits to confirm that the management of patients post myocardial infarction (heart attack) were carried out in line with National Institute for Health and Care Excellence guideline 172.

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); or Somerset Practice Quality Scheme (SPQS); SPQS is a federation led initiative being piloted in the Somerset area covering locally centred performance data. For example, we saw an audit regarding medicines optimisation designed to improve areas of quality, patient safety or unmet need to link with the strategic aims of the Somerset Clinical Commissioning Group. Following the audit, the GPs carried out medication reviews for patients in these categories and altered their prescribing practice, in line with the results and guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF, SPQS and performance against national screening programmes to monitor outcomes for patients. For example, the majority of patients diagnosed with diabetes, stroke, hypertension and heart failure had an annual flu vaccination. We saw from this audit outcome the practice was in-line with local standards for QOF in asthma and chronic obstructive pulmonary disease (lung disease).

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

There was a protocol for repeat prescribing which was in line with national guidance. In line with this, staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. The evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had implemented 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 improve methods of recognising patients who needed the added support that came from placing them on the palliative care register.

The practice also participated in local benchmarking run by the clinical commissioning group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable or better than other services in the area. For example, the practice was in the best 10% for prevalence of providing care and support to patients with dementia, obesity and osteoporosis.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with one having additional diplomas in family planning, and two with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example the management of diabetes.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, in the administration of vaccines, cervical cytology, sexual health and diabetes. Those with extended roles for example, seeing patients with long-term conditions such as asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

Good

Are services effective?

(for example, treatment is effective)

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 communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up appropriately.

The practice was commissioned for the new 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 that the policy for actioning hospital communications was working well in this respect.

The practice held regular multidisciplinary team meetings to discuss the needs of complex patients, for example those with end of life care needs, those on the shared care prescribing list or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and other professionals. Decisions about care planning were documented in a shared care record. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had also signed up to the electronic Summary Care Record and had this fully operational by April 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. Staff used an electronic patient record (Emis) to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. 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 do not attempt resuscitation orders. This 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. For example, the practice kept records and showed us 98% 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 saw clear evidence in patients records of how these decisions were made and noted. All clinical staff we spoke with demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child has the maturity to make their own decisions and to understand the implications of those decisions).

Good

Are services effective?

(for example, treatment is effective)

There was a practice policy for documenting consent for specific interventions. For example, for all yellow fever vaccinations and minor surgery, a patient's verbal and written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. The patients we spoke with told us their consent was always gained by clinical staff during investigative procedures.

The practice had clear documentary evidence where the use of restraint might be required including Best Interest assessments. Staff were able to describe the distinction between lawful and unlawful restraint and we saw from documentation that advice had been sought from the deprivation of liberty safeguarding officer where restraint was indicated.

Health promotion and prevention

The practice had met with the Public Health team from the local authority and the Clinical Commissioning Group (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 local area. This information was used to help focus health promotion activity.

We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering opportunistic chlamydia screening to patients aged 18 to 25 years.

NHS Health Checks for patients aged 40 to 75 years was now provided by an external contractor, 'To Health'. The outcomes from these assessments were sent to the practice and where concerns were indicated GPs arranged for patients to have appointments booked for further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all were offered an annual physical health check. Practice records showed 98% had received a check up in the last 12 months. The practice had also identified the smoking status of the majority of patients over the age of 16 and actively offered smoking cessation clinics to these patients through the 'Solutions 4 Health' service.

The practice's performance for cervical smear uptake was 72%, which was in line with others in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears and other similar types of appointments.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. The practice is a registered Yellow Fever vaccination centre. Last year's performance for all immunisations was in line with the CCG average, and again there was a clear policy for following up non-attenders by a named member of staff.

For older patients using the practice a register was kept of patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. Up to date care plans were maintained and shared with other providers. All patients discharged from hospital had a follow-up consultation where it was indicated. Patients received structured annual medication reviews where they were receiving multiple medicines. We saw evidence of multidisciplinary case management meetings for patients at high risk. There was a named GP for patients over 75 years.

Patients with long term conditions had structured annual reviews for their various conditions for example, diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. Patients assessed at risk were given preventative care for example almost 90% of patients diagnosed with diabetes had an influenza immunisation in the preceding year. The practice had adopted the use of Summary Care records.

The practice had a system for risk stratifying patients to identify those at high risk of developing long term conditions using the electronic patient record. We saw evidence of multidisciplinary case management discussions in patients' notes and saw a named GP was available to these patients to manage their care.

Families, children and young people were positively supported by the practice. We saw the practice achieved 100% immunisation rates for all standard 12 month old children's immunisations. Information available in the practice and discussions with staff showed there was clear

Good

Are services effective?

(for example, treatment is effective)

signposting of young people towards sexual health clinics and offering extra services such as contraception advice. There was evidence of multidisciplinary team working with midwives, community nurses and health visitors.

Details of patients whose circumstances may make them vulnerable including homeless people and those with a diagnosed learning disability were held on a register by the practice. We saw 98% of patients with learning disabilities had received an annual follow-up review appointment. We saw evidence of multidisciplinary case management discussions in patients' notes and saw a named GP was available to these patients. Information available in the practice and discussions with staff showed there was clear signposting of patients to various local support groups or third sector organisations such as the Stroke Association and Diabetes UK. The practice had developed an innovative approach to support vulnerable patients with chaotic lifestyles who required Med 3 sick notes to access benefits. They had identified lost sick notes caused delays in accessing benefits which subsequently impacted on patients' health. The practice established an arrangement with the Department of Work and Pensions (DWP) whereby the sick notes were emailed directly to the DWP. This approach resulted in patients receiving their benefits on time and without the stress of coping with lost forms.

All patients diagnosed with dementia had been reviewed in a face-to-face review in the preceding 12 months. Patients experiencing poor mental health had access to a named GP. The practice provided follow up appointments to patients with mental health problems who attend A&E where the need was indicated. We saw evidence of multidisciplinary case management discussions in patients' notes. Staff told us about signposting patients to relevant support groups or third sector organisations such as Mind and how they encouraged self-referral to local 'Talking Therapies' support.

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 and a report about patients undertaken by the practice's patient participation group (PPG) in March 2015. 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 'above average' for patients who rated the practice as good or very good. The practice was also around average for its satisfaction scores on consultations with doctors and nurses with 83% of practice respondents saying the GP was good at listening to them and 92% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 31 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. Two comments were less positive but there were no common themes to these. We also spoke with four patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private.

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

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

Patients whose circumstances may make them vulnerable were able to access the practice without fear of stigma or prejudice. We observed staff treating people from these groups in a sensitive manner. Where language may have been a barrier we saw information posters provided in three languages including Polish and Spanish. Patients experiencing poor mental health were able to access the practice and were treated in a supportive manner. The majority of patients in these groups were known individually by all staff and their specific needs were responded to sensitively.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example, data from the national patient survey showed 79% of practice respondents said the GP involved them in care decisions and 87% felt the GP was good at explaining treatment and results. Both these results were similar to the Clinical Commissioning Group average.

Patients we spoke with on the day of our inspection told us that health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They also told us they felt listened to and supported by staff and had sufficient time during consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received was also positive and aligned with these views.

Good

Are services caring?

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

We saw evidence of care plans for older patients and those with long term conditions and patient involvement in agreeing these.

Patient/carer support to cope emotionally with care and treatment

The patients we spoke with on the day of our inspection and the comment cards we received were consistent in praising the practice staff for their sensitive and caring nature. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices and information leaflets in the patient waiting room, on the TV screen and patient website also told 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. A particularly useful booklet titled "If only I'd known that" was also freely available to patients and provided a wealth of information relevant to a carers needs.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage delivery challenges to its population. These included, encouraging communities and individuals to take more control of and responsibility for their own health and wellbeing. Other examples were developing joined-up person-centred care, transforming the effectiveness and efficiency of urgent and acute care across all services and sustaining and continually improving the quality of all services. These points were integral to the practices vision and aims.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, providing access to a GP of choice through online booking and introducing GP triage appointments to reduce waiting times in the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, those with a learning disability, vulnerable patients, the unemployed, patients from other countries and patients with drug and alcohol problems.

The practice had a population of mainly English speaking patients. Approximately 28% of patients came from Polish or other Eastern European countries, though it could cater for other different languages through translation services. The practice had access to online and telephone translation services.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed that they had completed the equality and diversity training in February 2014 and that equality and diversity was regularly discussed at staff appraisals and team events.

The premises and services had been expanded and adapted in 2011 to meet the needs of patient with disabilities. Waiting areas had increased in size, consulting rooms had been made more accessible and disabled parking was provided. We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice, facilities including baby changing facilities were available.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Patients whose circumstances may make them vulnerable or who may be living in vulnerable circumstances were easily identified by the patient record system. People were easily able to register with the practice, including those with "no fixed abode" care of the practice's address; people not registered at the practice were able to access appointments by approaching the practice directly. The practice provided support to all patients living in a local homeless person's hostel as well as 90 patients living in learning disability housing schemes or homes in the area.

Access to the service

Appointments were available from 8:00 am to 6:30 pm on weekdays with GPs and practice nurse taking calls from patients between 8:00 am and 9:00 am each day to identify the most appropriate appointment for patients. The practice closed for staff training on the second Monday of each month between 12.30 pm and 2:00 pm.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were arrangements in place to ensure patients received urgent medical assistance when the practice was closed. If

Good

Are services responsive to people's needs?

(for example, to feedback?)

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.

All patients received 15 minute appointments and longer appointments were also available for patients who needed them and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to nine local learning disability homes by a named GP and to those patients who needed one. Patients with a learning disability had their medicines reviewed at least three times a year and more often if they had complex needs.

Patients were generally satisfied with the appointments system. They confirmed that they could see a doctor on the same day if they needed to. They also said they could see another doctor if there was a wait to see the doctor of their choice. 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, one patient we spoke with told us how they needed an urgent appointment that day and had been provided with an immediate appointment.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example, almost 91% of patients were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 77% and national average of 76%. Approximately 96% of patients described their experience of making an appointment as good compared to the CCG average of 80% and national average of 74%. Just over 79% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69% and national average of 65%. About 88% of patients said they could get through easily to the surgery by phone compared to the CCG average of 77% and national average of 72%.

Older people and people with long-term conditions received home visits where needed and longer appointments if required. Families, children and young people had access to appointments outside of school hours and the premises were suitable for children and young people. An online booking system was available on the practice's website and was easy to use. Telephone consultations were available through a triage system where appropriate.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. For example, posters were displayed in the waiting area and information was available on the practices website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at three complaints received since the start of the year which had been provided in person, in writing or by email. We found all had been managed in line with the practices complaints policy. The complaints had been dealt with in a timely way and the practice had been open and transparent when dealing with the complaint. We saw staff had spoken with the patient involved, had sent an apology or had been invited into the practice to discuss the events leading to the complaint.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on. For example, increasing appointment length to 15 minutes following concerns that a patient had been rushed by a locum GP.

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 five year business plan. These values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included; encouraging and supporting change for the benefit of the patient; being open, transparent and honest in all the practice does; being non- judgemental and accept patients as they are and seeking to continuously improve.

We spoke with eight members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at eight of these policies and procedures and most staff confirmed they had read the policies either during their induction training or when a policy was updated. All eight policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice used the Somerset Practice Quality Scheme (SPQS) and to a lesser extent the Quality and Outcomes Framework (QOF) to measure its performance. The data for this practice showed it was performing in line with national standards. We saw that SPQS data was regularly discussed at monthly 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, infection control audits which brought about changes to cleaning routines and a mini audit about the management of patients with chronic obstructive pulmonary disease (COPD) which resulted in patients being monitored and reviewed at least annually. Other audits carried out included, the management of patients post myocardial infarction (heart attack**),** A&E attendances, prescribing of antipsychotic medicines and vaccine storage.

The practice had arrangements for identifying, recording and managing risks. The practice manager showed us risk assessments which addressed a wide range of potential issues. For example, ensuring the premises maintenance was managed appropriately. We saw the risks were discussed at relevant staff meetings and were updated. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented.

Leadership, openness and transparency

We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team away days were held every six months.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example, induction policy and recruitment which were in place to support staff. We were shown computer based information which was available to all staff, which included policies about equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, suggestion cards and complaints received. The practice had an active patient participation group (PPG) which had a small core of active members. The PPG included representatives from various population groups including working people or those who recently retired and those with long term conditions. The PPG had carried out annual reports and met every two months. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website.

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 staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff also told us about social events for staff which were provided by the senior partner as well as a Christmas evening out paid for by the practice and other social gatherings. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients and commented positively about the 'family' nature of the practice.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training sessions each month.

The practice was a training practice providing experience and support to medical students in their third and fourth years of training.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings to ensure the practice improved outcomes for patients. For example, improved protocols for pharmacy staff when collecting prescriptions from the practice. The practice had very recently merged with another local practice and was in the process of re-registering with the Care Quality Commission. It was planned to establish some joint sharing of learning from events and occurrences as well as shared training opportunities to help improve outcomes for patients.