Drs Hanson, Perry, Paisley, Ashworth, Hammerton and Symons

Quality Report

Holway Green,
Upper Holway Road,
Taunton.
Somerset
TA1 2QA
Tel: 01823 282147
Website: www.warwickhouse.org.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Drs Hanson, Perry, Paisley, Ashworth, Hammerton and Symons (Warwick House Medical Centre) on 10 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led 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 living 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 accidents, incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and learnt from their investigations.
- Risks to patients were assessed and appropriately 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.
- Care and treatment of patients was carried out effectively by appropriately skilled staff.
- 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.

Summary of findings

- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments always available the same day.
- The practice had suitable 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 several areas of outstanding practice including:

- One of the nurses had a lead role in a local peer group for respiratory care and delivered learning sessions to the network four times a year. They also benefitted from peer support through the network and were able to share best practice with colleagues which benefitted patients at the practice and the wider community.
- The practice had undertaken a Medical Protection Society safety culture survey in February 2015 to ensure a "safety first "approach guided the practice's approach to support patient safety.

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

The provider should:

- Ensure arrangements are in place to agree the frequency of fire evacuation test procedures.
- Consider ways to ensure consistent recording of best interest decisions.

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 the National Institute for Health and Care Excellence and used it routinely. Patients' 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 for patients about the services available was easy to understand and accessible. 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 Somerset 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 patients. Nationally reported data showed that 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 that their health and medication 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. A nurse had received additional training in respiratory conditions and gained a diploma in Asthma care as a direct result of a financial donation. This enabled significantly more patients to attend clinics in respiratory care.

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 that 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. The practice had completed the Royal College of General Practitioners safeguarding self-assessment tool for children and had implemented systems to ensure vulnerable children known to the practice were kept safe.

Summary of findings

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of patients 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 patients with a learning disability and 95% of these patients had received a follow-up. It offered longer appointments for patients with a learning disability.

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 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). The majority of 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 advance care planning for patients with dementia.

The practice informed 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 on how to care for patients with mental health needs and dementia.

Summary of findings

What people who use the service say

We spoke with six patients visiting the practice during our inspection, three members of the patient participation group and received 35 Care Quality Commission comment cards from patients who visited the practice. We saw the results of the last Patient Participation Group report dated 30 March 2015. The practice also shared their findings from the current 'friends and family' survey for the practice. We looked at the NHS Choices website for the practice 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.

The majority of comments from patients were positive and praised the GPs and nurses who provided their treatment. For example; about seeing the same GP when requested and about being seem promptly when their needs required urgent support. Other comments included statements about the practice providing appointments with their preferred GP or nurse, compliments about the doctors helping patients to understand their condition and about a clean and safe environment. The patient participation group members we met spoke positively about the GPs and receptionists as well as the practice manager and about how responsive the practice was to their suggestions for improvement.

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 83% of patients saying it was easy to get through by telephone compared to the Clinical Commissioning Group (CCG) average of 77%. The most recent GP survey showed 94% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online systems to book and cancel appointments and to arrange repeat prescriptions.

Patients told us their human rights were observed and they were treated in privacy and with dignity during consultations. They told us they found the reception area was generally private enough for most discussions they needed to make. Patients told us they had been attending the practice for many years and they were always treated well and received good care and treatment. The GP survey showed 83% of patients said the last GP they saw or spoke with was good at giving them enough time and 82% said the GP treated them with care and concern.

Patients told us the practice was always kept clean and tidy and that information was easily available about how to help themselves with minor illnesses. Patients told us that 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

The provider should:

- Ensure arrangements are in place to agree the frequency of fire evacuation test procedures.
- Consider ways to ensure consistent recording of best interest decisions.

Summary of findings

Outstanding practice

- One of the nurses had a lead role in a local peer group for respiratory care and delivered learning sessions to the network four times a year. They also benefitted from peer support through the network and were able to share best practice with colleagues which benefitted patients at the practice and the wider community.
- The practice had undertaken a Medical Protection Society safety culture survey in February 2015 to ensure a “safety first “approach guided the practice’s approach to support patient safety.

Drs Hanson, Perry, Paisley, Ashworth, Hammerton and Symons

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 manager

Background to Drs Hanson, Perry, Paisley, Ashworth, Hammerton and Symons

Drs Hanson, Perry, Paisley, Ashworth, Hammerton and Symons, Warwick House Medical Centre, Holway Green, Upper Holway Road, Taunton. TA1 2QA is located a short distance from the centre of Taunton. The premises are purpose built and mainly on one level with a lift to a lower level. The practice has approximately 6,750 registered patients, this figure is growing monthly. The practice accepts patients from an area including Southern Taunton, Monkton Heathfield to the north East of Taunton, Knapp and Hatch Green to the East, Curland to the South and Poundisford and Corfe to the South West of Taunton. Full details are on the practice website.

There are six GP partners and a salaried GP and a team of clinical staff including a lead nurse, two practice nurses and a health care assistant. Four GPs are female and three are male, the hours contracted by GPs are equal to 5.5 whole time equivalent GPs based on 8 sessions per week.

Collectively the GPs provide 48 patient sessions each week. Additionally the three nurses employed equal to 1.6 whole time equivalent employees and a health care assistant (HCA) equal to 0.6 whole time equivalent HCA employed. Non-clinical staff included secretaries, support staff and a management team including a practice manager, patient services team, medical secretaries, practice administrator and other administrative and reception staff. The practice is a registered training practice with the Severn Deanery and supported an ST1 doctor at the time of our inspection (ST! doctors are in year one of their GP training).

The practice population ethnic profile is predominantly White British with an age distribution of male and female patients' broadly equivalent to national average figures. However the practice has noticeable fewer patients in the 20 to 39 years age categories. Practice data from the patient participation group report, March 2015 indicates there are approximately 9.5% of patients from other ethnic groups, the majority being patients from Eastern Europe. The average male life expectancy for the practice area is 80 years compared to the National average of 79; the female life expectancy for the practice is 84 years compared to the National average of 83 years.

The National GP Patient Survey published in January 2015 indicated just over 89% of patients said they would recommend the practice to someone new to the area. This was above the Somerset Clinical Commissioning Group average of about 83%. Local Public Health statistics

Detailed findings

(January 2014) demonstrate that Warwick House medical centre has a low level of social deprivation, the Index of Multiple Deprivation being 17.8 in compared to the National average of 23.6.

The practice has a General Medical Services (GMS) 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 living with dementia and minor surgery services. It also provides minor surgery such as vasectomy and nail care as well as 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.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by South Western Ambulance Service NHS Foundation Trust 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 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 living with dementia)

Before visiting Warwick House medical centre, 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 looked at information on the NHS Choices website and reviewed data held and compiled by the Care Quality Commission. 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 10 June 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included three GPs, the ST1 GP, a practice nurse, the health care assistant, the practice manager and six administrative and reception staff. We spoke with three members of the patient participation group, six patients and received Care Quality Commission comment cards from a further 35 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 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, an incident involving giving test results to a patient. This was reported and discussed at one of the practice audit meetings where it was decided to handle the concern as a significant event.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 18 months. These reports and minutes as well as our discussions 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, near misses and accidents. We reviewed records of significant events that had occurred during the last 18 months and saw this system was followed appropriately. Significant events was a standing item on the monthly CPD meeting agenda and were also discussed at practice meetings to review actions from relevant 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. They 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, being cautious when dealing with repeat prescription requests initiated by pharmacies to avoid the risk of patients having access to too many medicines. Where patients had been affected by something that 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 to practice staff using an online noticeboard. Information was disseminated by the practice manager to practice staff using an online noticeboard. This innovative idea appeared every day when staff first logged onto EMIS Web, which linked to the practice intranet noticeboard. All key information was posted on this noticeboard and provided a useful forum for passing on issues of note to 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 were discussed at CPD and practice 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 patients and adults. We saw the practice had undertaken a Medical Protection Society safety culture survey in February 2015 to ensure a safety culture was embedded in the practice to support patient safety. The practice worked to minimise risks by ensuring systems were robust and that when things went wrong, lessons were learnt and appropriate action was taken.

We looked at training records which showed that staff had received relevant role specific training about safeguarding based on Somerset Clinical Commissioning Group (CCG) advice. We saw that the GP with lead responsibility for safeguarding vulnerable children had received training at level three as required, the other GPs and nurses were working to level three and had received level two training. The practice had recognised further training was required and had arranged for further training to take place in September 2015. 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 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.

Good

Are services safe?

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. 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. Additionally we saw evidence that the practice had completed the Royal College of General Practitioners safeguarding self-assessment tool for children. (This is a tool for audit of general practice systems and processes relating to safeguarding children and young patients to determine whether practices are currently up to date with requirements). There were clear process flow charts to support staff in making safeguarding decisions and referrals. An 'essential practice' information pack had been produced and provided to all staff including locum GPs. Safeguarding was discussed in detail at all staff meetings and regular update training had been provided.

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. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms as well as 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). All nursing staff, including the health care assistant, had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice had systems for identifying children and young patients with a high number of A&E attendances and regularly monitored hospital attendances. The lead GP attended local children protection case conferences and reviews where appropriate; reports were sent if practice staff were unable to attend. We saw there were systems in place to follow up children who persistently failed to attend appointments for example, for childhood immunisations.

There were similar systems in place for older or other vulnerable patients and systems for reviewing repeat medicines for patients with co-morbidities and or who were prescribed multiple medicines.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

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.

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 meetings that noted the actions taken in response to a review of prescribing data. For example, the use of high cost medicines, patterns of antibiotic prescribing, the prescribing of hypnotic and sedative medicines and anti-psychotic prescribing within the practice.

There was a system in place for the management of high risk medicines such as blood thinning medicines and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been

produced in line with legal requirements and national and other guidance including the Care Quality Commissions mythbuster number 19 (Mythbusters are guidance documents for service providers). We saw sets of PGDs that had been updated in 2015. Where required staff also administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence that nurses 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.

We observed a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

The practice had established a service via their 'electronic prescriptions service' (EPS) for patients to pick up their dispensed prescriptions at local pharmacies and had systems in place to monitor how these medicines were collected. They also had arrangements in place to ensure that patients collecting medicines from these locations were given all the relevant information they required.

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.

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 intimate patient examinations or during minor surgery procedures. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a nurse with lead responsibility for infection control to provide advice about the practice infection control policy and carry out staff training and audits. All staff received induction training about infection control specific to their role and received regular updates. We saw evidence that the lead had carried out audits and that any improvements identified for action were completed on time. Minutes of practice meetings showed that 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.

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 that confirmed the practice was carrying out regular checks in line with this policy to reduce the risk of infection to staff and patients. Additionally the practice had undertaken a risk assessment in conjunction with an external provider for legionella and had identified the risk was sufficiently low to make formal testing unnecessary. The practice was waiting to be provided with an exemption certificate.

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. 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 carried out in March 2015; for example, the defibrillator, weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Staffing and recruitment

The practice had a recruitment policy that set 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).

Good

Are services safe?

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 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. These included regular 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 prominently 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. Risks both planned and unplanned, associated with service and staffing changes were required to be included on the log. We saw an example of this for where GP absences required covering 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 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. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. There were emergency processes in place for identifying acutely ill children and young patients and staff gave us examples of referrals made for example, acute high temperatures. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that 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 that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date, which they were.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia as indicated in mythbuster number 9 (Mythbusters are guidance documents for service providers. In this case, a suggested list of emergency medicines for GP practices). Processes were also in place to check whether emergency medicines and ancillary equipment were within their expiry date and suitable for use. All the 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 a heating company to contact if the heating system failed. The plan was last reviewed in 2015

The practice had carried out a fire risk assessment in 2012 which was due for review by an external contractor in July 2015. The risk assessment included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire alarm testing. The last noted fire evacuation of the practice took place in June 2012. We raised this with the practice manager who told us they would arrange for an evacuation to take place during June 2015 and more frequently thereafter.

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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and a nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this 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. 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 such as a dietician or optician. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they had lead responsibility for 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 supported all staff to review and discuss new best practice guidelines, for example, for the management of patients diagnosed with diabetes. Our review of the clinical meeting minutes confirmed that 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 that after patients were discharged from hospital they were followed up to ensure that 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's 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 scheduling clinical reviews, data input, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and admin team to support the practice to carry out clinical audits.

The practice showed us 21 clinical audits that had been undertaken in the last four years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, changes in the way end of life analgesia was provided, improved levels of urate measurements for patients diagnosed with Gout and improved recording of patients diagnosed with chronic obstructive pulmonary disease (COPD). Specifically in regard of patients diagnosed with Gout, the audit showed a positive increase from 52% to 90% of patients with a urate assay in the previous 12 months. Other examples included audits to confirm that the GPs who undertook minor surgical procedures, contraceptive implants and the insertion of intrauterine contraceptive devices were doing so in line with their registration and National Institute for Health and Care Excellence guidance.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Somerset Practice Quality Scheme (SPQS) (Practices participating in the SQPS work closely and collaboratively with other health organisations in Somerset, sharing highly skilled staff between practices to provide more advanced care of long term conditions, such as diabetes, and in the care of the frail and elderly)

Good

Are services effective?

(for example, treatment is effective)

and Quality and Outcomes Framework (QOF). (QOF is a voluntary incentive scheme for 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 drugs. Following the audit, the GPs carried out reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. 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 also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients.

- Performance for diabetes related indicators was similar or better to the national average.
- The dementia diagnosis rate was above the national average

Hypertension measures were not fully completed by the practice as it was not information gathered under the SPQS scheme requirements. The practice was aware of all the areas where performance was not in line with national or Somerset Clinical Commissioning Group (CCG) figures and we saw action plans setting out how these were being addressed.

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, noting that there was an expectation that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar to national figures. 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. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. We saw from minutes of meetings that these areas were discussed regularly by the practice. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. (Gold standards framework gives outstanding training to all those providing end of life care to ensure better lives for people and recognised standards of 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.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. For example, foreign students and patients diagnosed with learning disabilities. Structured annual reviews were also undertaken for patients with long term conditions for example those diagnosed with diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. We were shown data that 95% of these 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. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, medicines prescribing, diabetes and long term condition management.

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 five having additional diplomas in sexual and reproductive medicine, two with diplomas in children's health and five with diplomas in obstetrics and gynaecology. All GPs were up to date with their yearly continuing professional development requirements and all either had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every

Good

Are services effective?

(for example, treatment is effective)

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, annual update training as well as in clinical areas such as diabetes and asthma. We were also provided with evidence which showed where the practice received financial donations these were spent on staff development in areas of need identified by the practice. For example, a nurse had received additional training in respiratory conditions and gained a diploma in Asthma care as a direct result of a financial donation. This enabled significantly more patients to attend clinics in respiratory care.

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 trainee we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines, cervical cytology (smear tests) and respiratory care. 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. One of the nurses had a lead role in a local peer group for respiratory care and delivered learning sessions to the network four times a year. They also benefitted from peer support through the network and were able to share best practice with colleagues which benefitted patients at the practice and the wider community.

Staff files we reviewed showed that 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 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. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for 19 ambulatory (outpatient) care sensitive conditions per 1000 population (2013/2014) for the practice were relatively high at 16.8 compared to the national average of 13.6. 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 that 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 that no follow-ups were missed.

The practice held multidisciplinary team meetings quarterly 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, nursing home staff, palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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

Good

Are services effective?

(for example, treatment is effective)

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 also signed up to the electronic Summary Care Record, this was 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 WEB) 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 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 that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. 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 a protocol to help staff. For example, with making do not attempt resuscitation orders. The protocol 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 living 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. The practice records and showed all care plans had been reviewed in the 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. Decisions were recorded on the patient record however, these were recorded inconsistently and in a very few cases lacked full information about how the decision was reached. 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 three 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 at routine appointments and offering smoking cessation advice to smokers.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of the majority of patients over the age of 16 and actively offered smoking cessation clinics to all patients who wanted to give up. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

Good

Are services effective?

(for example, treatment is effective)

The practice's performance for the cervical screening programme was 82.6%, which was above the national average of 81.9%. There was a policy to offer reminders for patients who did not attend for their cervical screening test. A member of staff had responsibility for following up patients who did not attend. The practice also 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 78.6%, and at risk groups 62.7%. These were above the national average figures.
- Childhood immunisation rates for the vaccinations given to under twos were 100%, and for five year olds they ranged from 92.9% to 100%. These were above the CCG averages.

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 (118 patients), a survey undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each of the practice's partners. (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 'among the best' for patients who rated the practice as good or very good. The practice was also broadly similar to other practices for its satisfaction scores on consultations with doctors and nurses. For example:

- 87.5% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87.2%.
- 82.7% said the GP gave them enough time compared to the CCG average of 88.5% and national average of 85.3%.
- 91.2% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.8% and national average of 92.2%
- 81.7% said the nurse was good at listening to them compared to the CCG average of 81.5% and national average 79.1%.
- 80.3% said the nurse gave them enough time compared to the CCG average of 82.5% and national average of 80.2%.
- 87.6% said they had confidence and trust in the last nurse they saw compared to the CCG average of 88% and national average of 85.5%

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 35 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and provided them with choices of treatment. They also said staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Four comments were less positive but there were no common themes to these. We also spoke with six 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. 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 prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 92% said they found the receptionists at the practice helpful compared to the CCG average of 89.1% and national average of 86.9%.

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 notice 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.

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. We

observed staff treating patients from these groups in a sensitive manner. Training was available to staff on how to deal sympathetically with all groups of patients and in managing challenging behaviour.

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:

- 81.6% said the last GP they saw was good at explaining tests and treatments compared to the Clinical Commissioning Group (CCG) average of 85.6% and national average of 82%.
- 78.2% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78.4% and national average of 74.6%.
- 74.6% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 79.2% and national average of 76.7%.
- 69.1% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 67.4% and national average of 66.2%.

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.

Staff told us that translation services were available for patients who did not have English as a first language. We saw a hearing loop was available in the reception area.

We saw evidence of care plans for older patients and patient involvement in agreeing these. The plans included information about their end of life care planning. Similar arrangements were in place for the most vulnerable patients with long-term conditions. We saw evidence that children and young patients were treated in an age-appropriate way, recognised as individuals with their preferences considered. Young person's appointments were available with the nurse practitioner where young patients could discuss contraception and receive sexual heath advice and information in confidence.

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:

- 82.4% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86.1% and national average of 82.7%.
- 77.3% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.8% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received made statements which suggested a much higher level of emotional support than with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required particularly at times of personal difficulty.

Notices 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.

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. Patients 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. For example;

- The current list size was 6784;
- Elderly patients over the age of 65 years accounted for 1643 or 24% of the list, with 769 over the age of 75 equating to 11.3% of the list;
- There were 1100 children under the age of 16 equal to 16.2% of the list with 334 or 4.9% under the age of 5 years;
- The working age list size was 3950 including patients between the ages of 18-65 years, making up the largest, 58%, section of the list;
- 1430 patients had a recognised mental health diagnosis, these patients made up 21% of the list;
- The number of patients diagnosed with a learning disability was small, 45 or 0.47%. 25 were on the practices learning disability register;
- Patients with long term conditions equalled 1624 or 23.9% of the practice list.

The practice had responded to these patients needs by providing a range of services and clinics which reflected the population needs such as family planning services, ante-natal clinics, child immunisation clinics, well person checks, diabetic clinics, asthma clinics, a vasectomy service and minor surgery sessions. These were complemented by a number of other services such as osteopathy and acupuncture as well as the practice being a yellow fever vaccination centre.

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 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 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, longer nurse appointments, providing patient information events and adding a visible safety strip to the glass entrance doors.

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, consideration of carers needs when patients became unwell and supporting foreign students at a local college. The majority of the practice population were English speaking patients but 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 about advocacy services available for patients in leaflets the practice provided.

The premises and services had been designed to meet the needs of patients with disabilities. The practice was accessible to patients with mobility difficulties as most facilities were all on one level and a lift provided access to lower consulting rooms. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and pushchairs and a wheelchair was provided by the practice if needed. This made movement around the practice easier and helped to maintain patients' independence.

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records and referrals could be made to a local homeless persons centre.

Good

Are services responsive to people's needs?

(for example, to feedback?)

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

One of the practices GPs carried out a weekly ward round at a secure unit of the local psychiatric hospital in support of patient health and wellbeing.

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 the last 12 months and that equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday. Appointments were available from 8:30 am to 6:30 pm on weekdays. Extended hours appointments were available until 7:00 pm on Monday to Thursday evenings with bookable appointments also available every other Saturday morning.

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 also 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 on 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 also included appointments with a named GP or nurse. Home visits were made to ten local care homes by a named GP and to those patients who needed one.

The practice provided text message reminders to patients about their appointments and there was information about how to sign up for these in the waiting area and on the practices website. The practice also contacted all patients by telephone where they had a double appointment booked to ensure the patient attended and reduce the number of missed appointments.

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:

- 80.5% were satisfied with the practice's opening hours compared to the Clinical Commissioning Group (CCG) average of 77.5% and national average of 75.7%.
- 85.6% described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 67.4% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 83.4% said they could get through easily to the surgery by phone compared to the CCG average of 76.8% and national average of 71.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. . They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking four weeks in advance. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Appointments were available outside of school hours and the premises were suitable for children and young patients. Young person's appointments were available on Friday afternoons with the practice nurse where young patients could discuss contraception and receive sexual heath advice and information in confidence.

An online booking system which benefitted the working population was available and easy to use as well as telephone consultations where appropriate. The practice supported patients to return to work through the fit note scheme. (A fit note allows GPs and other healthcare professionals to give patients more information about how a patient's condition affects their ability to work. This will help employers understand how they might help the patient return to work sooner or stay in work).

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 GP who was the responsible person who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw that information was available to help patients understand the complaints system for example in posters displayed in the waiting area and in the practice leaflet. 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 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. We saw there was an openness and transparency when dealing with the complaint and complainants received a letter of apology and or a telephone call where this was appropriate. Lessons had been learned from individual complaints and had been acted on. Improvements had been made to the quality of care as a result for example, reducing noise levels near the reception desk.

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 nurturing a friendly, informal and supportive environment, delivering high quality, patient-centred care and providing safe, caring patient experiences.

All the members of staff we spoke with knew and understood the vision and values of the practice. They told us they 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 and saw that staff had discussed and agreed that the vision and values were still current.

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 ten of these policies and procedures and most staff were able to confirm that they had read the policies and when. All ten 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 one of the partners had lead responsibility for child and adult safeguarding. All members of staff we spoke with were clear about their own roles and responsibilities within the practice. They all told us they felt valued, very well supported and knew who to go to in the practice with any concerns or suggestions for improvement.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Somerset Practice Quality Scheme (SPQS) and Quality and Outcomes Framework (QOF) 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 data for this practice showed it was performing in line with national standards. We saw that quality data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice also 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, in regard of prescribing, clinical care and infection control. Evidence from other data 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 that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the Somerset Clinical Commissioning Group (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. The practice monitored risks regularly to identify any areas that needed addressing.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes on the CPD minutes viewer from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies for example, disciplinary procedures, induction policy and management of sickness absence which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections on equality, 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 also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in

Are services well-led?

Good

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

discussions about how to run the practice and how to develop the practice: 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. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings, were confident in doing so and felt supported if they did. We also noted that team away days were held every six months. Staff said they felt respected, valued and supported, particularly by the partners in the practice. The management team rewarded staff for their hard work; staff told us about receiving shopping vouchers in acknowledgement of their hard work following a busy period in the practice.

The practice recognised the value of staff being involved in activities outside of the practice and actively encouraged involvement. Involvements included, GPs providing representation on the Local Medical Committee and Somerset Clinical Commissioning Group acting as medical officer to a private psychiatric hospital and providing sessions for a community sexual health service. Two of the GP Partners undertook out of hours sessions. The registered manager was the deputy medical director of Somerset Primary Health – a GP owned and led provider organisation. One of the GPs was a GP appraiser and a GP trainer and the practice manager participated in the local practice manager forum and Taunton Deane Federation, as well as undertaking consultancy work and mentoring other practice managers

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, thank you cards and letters, and complaints received. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). It had an active PPG which included representatives from various population groups, including the recently retired and those with long term conditions. The PPG had carried out surveys and currently met every month. 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 were available on the practice website. We spoke with three members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice.

Following feedback from patients and staff the patient participation group had put on a number of patient information events (PIE) in conjunction with the practice. These events had proved popular with patients from the practice with other patients also invited. The last event about driving safety for patients over the age of 60 was attended by 27 patients. A previous event covered emergency resuscitation and a future one would cover diabetes management.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in

shaping the service delivered at the practice through expanding the PPG. The practice website had information about how to become a PPG member.

The practice had also gathered feedback from staff through for example, 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 that they had asked for specific training around ear irrigation at the staff meeting 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 that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at three staff files and saw that regular appraisals including 360 degree feedback, took place which included a personal development plan. (360 feedback is a performance appraisal system that gathers feedback on an individual from a number of sources, typically including colleagues, direct reports and people who receive services). Staff told us that the practice was very supportive of training and that they had staff away days where guest speakers and trainers attended.

The practice was a GP training practice serving the Severn Deanery. The practice supported medical students and

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foundation doctors. We spoke with a registrar ST1 doctor (a doctor in their first year of training) during our inspection; they were very complimentary about the support they received from the practice, their GP supervisor and other GPs in the practice.

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, being cautious when dealing with repeat prescription requests initiated by pharmacies to avoid the risk of patients having access to too many medicines.