# Pudding Pie Lane Surgery

## Quality Report

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

## Ratings

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

# Summary of findings

## Contents



## Overall summary

**Letter from the Chief Inspector of General Practice**

Pudding Pie Lane Surgery in situated in a rural area of North Somerset with approximately 9000 registered patients. Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the North Somerset Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We undertook a comprehensive announced inspection on 3 February 2015. Our inspection team was led by a Care Quality Commission (CQC) Lead Inspector and GP specialist advisor. Overall the practice is rated as good.

Specifically, we found the practice to be outstanding for providing responsive services and good for providing well-led, safe, effective and caring services. It was also good for providing services for all of the population groups.

Our key findings 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 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 appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

# Summary of findings

- There was a 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:

- Pudding Pie Lane Surgery has staff who were registered as "dementia friends" and support staff to undertake training to be dementia champions.
- The practice has a number of voluntary drivers who can assist patients to attend the practice for treatment. The GPs provide free medical assessments needed by the volunteers for insurance purposes for their role.
- The dispensary based within the service delivers medicines to collection points around the local area, such as the local luncheon club.
- The practice hosts a "Leg Ulcer Club" and treats local patients alongside the community nurses; patients attending the service are invited to stay for tea and cake. This service was set up to treat patients and combat social isolation amongst older patients who may be housebound. The service has volunteer transport for patients who need it.
- The practice has identified "expert patients" with diabetes to participate in a buddying scheme with other diagnosed diabetic patients to support self-management of their illness.

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

In addition the provider should:

- Have arrangements in place so that there is managerial oversight of all the areas of the service.

**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 safe. We found the practice had systems, processes and practices in place to keep people safe and these were communicated to staff. Staff understood their responsibilities to raise concerns and incidents. Safety was monitored using information from a range of sources. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice also had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

**Are services effective?**

Good

The practice is rated as good for effective. The practice demonstrated patients' needs assessed and care and treatment was delivered in line with current legislation, standards and evidence-based guidance. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits to evaluate prescribed treatment. We found staff had the skills, knowledge and experience to deliver effective care and treatment. Patient's consent to care and treatment was always sought in line with legislation and guidance, such as written consent for insertion of subcutaneous medicines.

**Are services caring?**

Good

The practice is rated as good for caring. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. We were given examples of how the practice had gone over and above what was expected of the service. We observed a strong patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieve this. We were told by all the patients we spoke with how much they valued the relationship they had with the nurses and GPs and practice. Patients were treated as individuals and partners in their care. Several patients told us the GPs provided continuity of care and had contacted them outside of normal working hours to provide information and support. We were given examples of patient's making choices and being informed of the best care

# Summary of findings

pathways for their treatment. We found the practice routinely identified patients with caring responsibilities and supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

**Are services responsive to people's needs?**

**Outstanding** ☆

The practice is rated as outstanding for responsive. It reviewed the needs of its local population and engaged with the NHSE Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found there was continuity of care, with urgent and routine appointments available the same day. The practice had excellent facilities and was equipped to treat patients and meet their needs. We found the practice was involved with providing integrated health services and embedded these in the local community services such as using community events to provide flu vaccinations. The practice was federated and worked in an innovative way to meet patient's needs for example, accessing the Prime Minister's Challenge Fund for patient weekend appointments. The practice was responsive to changing risks including deteriorating health and wellbeing or medical emergencies. 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. The practice had a clear vision with quality as its top priority. High standards were promoted and owned by all practice staff, and teams worked together. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients via surveys. 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 older people in its population and had a range of enhanced services, for example, the practice ensured the frail older patients were assessed for their potential risk of unplanned admissions and planned care to avoid them. It was responsive to the needs of older people and offered home visits to those unable to get to the practice. The practice also supported older patients living in residential or nursing homes locally. The practice hosted regular meetings for the local carers' organisation in order to promote support services and they had a carer's champion.

**People with long term conditions**

Good

The practice is rated as good for the care of people with long-term conditions. The practice provided specialist nurse support for conditions such as asthma, diabetes and heart disease. Patients' conditions were monitored and reviewed with planned appointments sent directly to them. We found patients were assessed and signposted to the most appropriate support. Vulnerable patients had a care plan which could include emergency medicines such as antibiotics or steroid therapy. The care plan was made available to the Out of Hours service. 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. The practice has identified "expert patients" with diabetes who participate in a self-care buddying scheme.

**Families, children and young people**

Good

The practice is rated as good for the population group of families, children and young people. Systems were in place for identifying and following-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. Patients told us and we saw evidence that children and young patients were treated in an age appropriate way and recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. Emergency processes were in place and referrals made for children and pregnant women who had a sudden deterioration in health. Young adults were able to access

# Summary of findings

confidential appointments with a GP. The practice had developed links with young people's organisations and the local college and was sourcing a smart phone application to engage with younger patients.

**Working age people (including those recently retired and students)**

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group. Appointments were available in the early morning and at weekends in an alternate practice.

**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 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. The practice worked collaboratively with community services to combat social isolation amongst patients who may be housebound. 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 population group of patients experiencing poor mental health (including patients with dementia). The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health including those with dementia. Pudding Pie Lane Surgery has staff who are registered as "dementia friends" .The practice also sign-posted patients who experienced poor mental health to various support groups or as appropriate to psychological therapies and self-help groups, and provided one-to-one support.

# Summary of findings

## What people who use the service say

We spoke with ten patients visiting the practice and we received 36 comment cards from patients who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the last Care Quality Commission inspection report about the practice.

The comments made or written by patients were very positive and praised the care and treatment they received. For example, patients had commented about seeing their preferred GP at most visits and about being involved in the care and treatment provided. Many patients had rated the service they experienced at the practice as excellent.

We reviewed the results from the national GP Patient Survey for 2013 and found the responses confirmed the experiences we heard from patients. The survey had found the proportion of patients who would recommend their GP surgery was 88% which was above the average for the Clinical Commissioning Group (CCG). 93% of respondents say the last GP they saw or spoke to was good at explaining tests and treatments which was above the CCG average and 93% of respondents say the last GP they saw or spoke to was good at giving them enough time again this was above the CCG average .

We found the practice had a virtual patient network (VPN) of 197 patients (2.1%). The gender and ethnicity of the virtual patient network was representative of the total practice patient population Information was circulated through the network via emails or newsletters. The practice invited patients from the network to be part of specific focus groups of usually 5 – 10 patients who met face to face. We spoke with patients who had been involved with the patient consultation groups. For example, we were told about a focus group which had been formed to provide feedback to NHS England about the recent change of location of the practice.

All of the patients we spoke with gave very positive feedback about the practice. In particular patients told us how much they valued the relationship they had with the GPs and nurses. Patients told us that they felt listened to and understood when they attended for consultations and treatment. We were told appointments took as long as was needed and no one felt rushed or hurried. Patients were very enthusiastic about the practice and overall interactions and experiences were described as excellent.

The practice had distributed a survey electronically to the VPN and on the website. Paper copies were available from the practice during the survey period of January – February 2014. All patients were asked to complete the survey anonymously and to provide demographic data. The responses were collated along with the comments made by patients. For example, patients said it was felt patients were not always aware that they could request a specific doctor for the Open Access appointment sessions. The practice had agreed to reinforce the availability of appointments and GPs in the newsletter. This was done by an article in March 2014 issue which told patients that requests to see a specific GP during Open Access could be made but may increase the waiting time for appointments. The practice had also commenced their current 'friends and family' survey.

## Areas for improvement

**Action the service SHOULD take to improve**

- Have arrangements in place so that there is managerial oversight of all the areas of the service.

# Summary of findings

## Outstanding practice

- Pudding Pie Lane Surgery has staff who were registered as "dementia friends" and support staff to undertake training to be dementia champions.
- The practice has a number of voluntary drivers who can assist patients to attend the practice for treatment. The GPs provide free medical assessments needed by the volunteers for insurance purposes for their role.
- The dispensary based within the service delivers medicines to collection points around the local area, such as the local luncheon club.
- The practice hosts a "Leg Ulcer Club" and treats local patients alongside the community nurses; patients attending the service are invited to stay for tea and cake. This service was set up to treat patients and combat social isolation amongst older patients who may be housebound. The service has volunteer transport for patients who need it.
- The practice has identified "expert patients" with diabetes to participate in a buddying scheme with other diagnosed diabetic patients to support self-management of their illness.

# Pudding Pie Lane Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

Our inspection team was led by a CQC Lead Inspector, a second CQC inspector, a nurse and a GP specialist advisor.

## Background to Pudding Pie Lane Surgery

Pudding Pie Lane Surgery is situated in a rural area of North Somerset. It has approximately 9000 patients registered with a majority ethnicity of White British. The practice provides services to approximately 20 small villages; it has a dispensary for patients who live 1.6km from a pharmacy.

The practice operates from two locations:

Pudding Pie Lane Surgery

Pudding Pie Lane

Langford

North Somerset

And a branch surgery at:

2 Richards Stores

Broad Street,

Wrington

North Somerset (this location was not visited.)

The practice is made up of five GP partners and one salaried GP. GP's of both genders are working alongside three qualified nurses and four health care assistants (all female). The practice has a general medical service contract and is a dispensing practice which means it provides its own patients with the medicines they are prescribed. The practice also has some additional enhanced services such as extended hours for pre booked appointments and unplanned admission avoidance. The practice is open on Monday to Friday 8.30am – 6.30pm and pre-booked appointments are available on Tuesday mornings from 6.30am. The branch surgery is open each morning for pre-booked appointments. There is always a GP on site whenever the practice is open.

The practice does not provide out of hour's services to its patients, this is provided by Bris Doc. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years old: 4.51%

5-14 years old: 11.38%

15-44 years old: 31.03%

45-64 years old: 30%

65-74 years old: 13.49%

75-84 years old: 7.03%

85+ years old: 2.55%

With 0.54% of patients in a residential or nursing home; the practice holds regular clinics at a local nursing home and extra care housing facility.

Information obtained from NHS England showed that the practice is in an area of low deprivation with a higher than England average number of patients over 75 years. The patient gender distribution was male 48.77% and female 51.23 %; GPs of both genders work at the practice.

# Detailed findings

The Langford site is a multi-purpose building which hosts services from other health care providers such as the North Somerset Community Partnership for podiatry and leg ulcer clinics. Other services are available for patients to access on a fee paying basis.

With effect from 11th September 2013 Wrington Vale Medical Practice, Long Ashton Surgery, Clevedon Riverside Group and Yeo Vale Medical Practice started to work together as a federation of practices under the consortium name of the LAWCY Group. The practices work closely together for the purposes of interacting with North Somerset Clinical Commissioning Group (CCG) and NHS England. The four practices, with a combined patient population of approximately 35,000 patients, work together on clinical and business projects to enhance patient care, patient choice, and quality of primary care services. An example of this is the additional weekend access for appointments.

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

## Why we carried out this inspection

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

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

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we held about the practice and asked other organisations to share what they knew. This included the North Somerset Clinical Commissioning Group (CCG), NHS England and Healthwatch.

We carried out an announced visit on 3 February 2015 2014 between 8.30am - 5pm.

During our visit we spoke with a range of staff, including GPs, nurses, the assistant practice manager and administrative staff.

We also spoke with patients who used the service. We observed how patients were being cared for and reviewed the patient information database to see how information was used and stored by the practice. We reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

The inspection team always looks at the following six population areas at each inspection:

- Vulnerable older patients (over 75s)
- Patients with long term conditions
- Mothers, children and young patients
- Working age population and those recently retired
- Patients in vulnerable circumstances who may have poor access to primary care
- Patients experiencing poor mental health.

Good

# Are services safe?

## Our findings

**Safe track record**

The practice used a range of information to identify risks and improve quality in relation to patient safety. We spoke with five GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about 13 incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. Events linked to the dispensary service errors or occurrences were also reviewed.

Where events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to other care providers who were supporting the patients concerned.

We were told and saw evidence of national patient safety alerts as well as comments and complaints received from patients were responded to appropriately. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents or events. We reviewed the practice safety record and incident reports which showed no major incidents. The practice used an electronic patient record system. Any significant medical concerns or additional support needs were added as alerts to patients' records. These appeared when a record was opened and alerted the GP or nurse to significant issues relating to the patient and their care. For example, the practice had a child protection coding process to ensure practitioners were alerted if patients had a protection plan. Staff also understood that patients may be supported by a carer or a relative to act as an advocate for them, and this information was recorded on the patient record.

The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the North Somerset Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits and complaints.

**Learning and improvement from safety incidents**

The practice had a system in place for reporting, recording and monitoring significant events. There were records of significant events that had occurred during the last year, and we were able to review these with individual GPs. Significant events were a standing item on the practice meeting agenda. The significant events were recorded in each GPs professional training and development record and we were able to read the actions from past significant events. There was evidence the practice had learned from these, the practice recorded how the learning was shared with relevant staff. For example, we reviewed an incident related to the prescribing of a reducing dosage of medicine. We found the electronic patient record system produced repeat prescriptions and acute prescriptions, however a change in patient information did not mean that a repeat prescription was automatically cancelled, and the patient received the prescription without the correct directions. We were told this learning had been shared with the team and information about this issue shared with the system provider.

National patient safety alerts were disseminated by the senior partner to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. Safety alerts and information was available in the electronic records for staff to readily access. The practice told us how they managed and responded to significant events and complaints received. They had identified they needed to look at the root cause of events and complaints, and involved all staff in finding solutions.

**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 about 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, 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 GP with lead responsibility for safeguarding vulnerable adults and children. They had

been trained and could demonstrate they had the necessary knowledge to enable them to fulfil this role however staff were unclear as to what level they had been trained in child protection. We received further information after the inspection that the training records had been reviewed and all GPs had achieved the training in child protection to level 3 as per the intercollegiate guidance. All staff we spoke with were aware who the lead staff were and who to speak with in the practice if they had a safeguarding concern. The practice demonstrated appropriate liaison with partner agencies such as the police and social services and held three monthly meetings with health visitors and midwives, where any risk were discussed and action agreed.

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, failure to attend for childhood immunisation.

We observed there was a chaperone policy, which was displayed on the waiting room noticeboard and in consulting rooms. Nursing staff were available to act as a chaperone, and had undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. We were told there were very few requests for this service.

**Medicines management**

We checked medicines stored in the treatment rooms and medicine refrigerators 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. Staff we spoke with explained how they followed the policy but had not always recorded their good practice. For example, rechecking the temperature of a refrigerator which had a reading outside the acceptable range. Vaccines were administered by nurses who used directions which had been produced to meet legal requirements and national guidance.

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. The practice did not have any controlled drugs.

There was a system in place for the management of high risk medicines, for example prescribing benzodiazepines. GPs and nurses were responsible for monitoring the effectiveness of diagnostic testing. An alert was placed on the computer system to ensure relevant tests had taken place and it was safe for the patient to continue taking prescribed medicine.

Patients ordered repeat prescriptions in person or online. The practice set a target of getting medicines to patients within 48 hours. We were told that if needed the practice was flexible and patients could request medicines and have a repeat prescription within a very short time frame.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely. We were told that printed prescription sheets remained in the printers overnight and this was a risk for the practice to address. We were informed following the inspection that they had changed the way in which they safeguarded blank prescription. Every night, each GP and the dispensary staff lock up the scripts in a drawer and then only take them out in the morning when they come back into surgery.

There was a protocol for repeat prescribing which was in line with national guidance and was followed in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure that patients' repeat prescriptions were still appropriate and necessary. This was overseen by the patient's GP so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any changes.

The practice had a GP who was the medicines management lead professional and they were able to describe the processes in place for reviewing prescribing and the oversight of the dispensary at the practice. We heard how information about the medicines prescribed at the practice was reviewed and discussed in team meetings and clinical audits. For example an assessment of antidepressant prescribing to ensure that duration of treatment and monitoring guidelines were in place and met NICE guidance.

Good

# Are services safe?

All repeat 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 offered a full range of primary medical services and was able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises. We met and spoke with staff working in the dispensary at the practice. Part of their service was to provide medicine 'dosette' boxes and they also offered an additional service of home delivery for those housebound patients. The dispensary provided a valued service to the rural communities and delivered to a luncheon club and communities in the surrounding areas using the volunteer transport service.The practice had arrangements in place to ensure the security of medicines, for example, all collected medicines were signed for and any not collected were returned to the practice. This system was only used for medicines which were not subject to specific storage conditions, such as refrigerated items or controlled drugs, which were collected directly from the dispensary at the practice.

Dispensing staff at the practice described and we were shown how they managed patient's prescriptions. Staff ensured prescriptions were signed before medicines were dispensed. We were shown the checks and the systems of monitoring for patients prescriptions and the dispensing at the practice. We heard how the dispensary had support from several suppliers which meant there was a reduced risk of not being able to obtain patients prescription medicines in a timely way.

The practice had a system in place to assess the quality of the dispensing process and had signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients of their dispensary. We saw the practice had their Standard Operating Procedures which were reviewed regularly. The dispensary staff maintained a risk log for any significant events.

Records showed that all members of staff involved in the dispensing process had received appropriate training and their competence was checked yearly. New staff were provided with training when appointed and were supported by experienced staff.

The practice had established a service for patients to pick up their dispensed prescriptions at different locations and had systems in place to monitor when and who collected these medicines. 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. There were cleaning schedules in place and cleaning records were kept. Hand hygiene technique signage was displayed in staff and patient toilets. Hand washing sinks with hand soap, hand gel and hand towel dispensers were available in treatment rooms. Patients we spoke with told us they always found the practice clean and had no concerns about cleanliness or infection control.

All staff received induction training about infection control specific to their role; further updates were arranged by the practice manager. We saw evidence there had been an audit of precautions and systems in 2014. Improvements identified for action were completed. The infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement control of infection measures. 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 in order to comply with the practice's infection control policy. There was also a policy for needle stick injury. We also saw the practice had received the NHS England information relating to the Ebola virus and ensured this information was available to staff and patients.

The practice provided evidence of a policy for the management, testing and investigation of legionella (bacteria found in the environment which can contaminate water systems in buildings). The new building was only completed in 2012 and the water system was subjected to testing prior to being occupied and we were given evidence of a retest in January 2015 The provider had a system to assess the whole building including the areas currently unoccupied to identify and mitigate any risk of legionella contamination.

**Equipment**

The practice was suitably designed and adequately equipped. The building, its fixtures and fittings were owned

and maintained by the practice who employed specialist contractors as needed. We saw equipment such as the weighing scales, blood pressure monitors and the electrocardiogram (ECG) machine were routinely available, serviced and calibrated where required. There was an automated external defibrillator (AED used to attempt to restart a person's heart in an emergency) centrally located and all staff were trained in its use.

All portable electrical equipment had been portable appliance tested (PAT); we found this testing had taken place recently. Equipment, such as couches, were wiped down and cleaned after use. When equipment became faulty or required replacement, it was referred to the practice partners who arranged for its replacement. Equipment such as the computer based record system were password protected and backed up to prevent data loss.

**Staffing and recruitment**

The practice had relevant staffing and recruitment policies in place to ensure staff were recruited and supported appropriately. 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 via the Disclosure and Barring Service. The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

All the staff we spoke with told us they felt well supported by the GPs and nursing team, as well as each other. They told us they felt skilled and supported in fulfilling their role. Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. 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 enough staff to maintain the smooth running of the practice and there were always enough staff on duty to ensure patients were kept safe. The practice did not use locum GPs or agency staff.

**Monitoring safety and responding to risk**

The practice was located in a purpose built environment .The maintenance of the building and external grounds, and the health and safety arrangements for the building were managed by the practice. We were shown the systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety statement on their website. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw that risks were discussed at GP partners' meetings and within team meetings. We saw a range of information was available in the practice which provided details of organisations patients or staff could contact if physical health emergencies or mental health crises occurred, either during or outside of practice opening times. The reception staff showed us contact telephone numbers of relevant organisations they could contact and there was a detailed emergency incident procedure available.

Staff told us how they recognised and responded to changing risks to patients and staff. Staff told us they had recently been trained in what to do in an urgent or emergency situation and about the practice's procedures in such circumstances.

**Arrangements to deal with emergencies and major incidents**

We were told there was always first aid equipment available on site when the practice was open. We looked at the accident recording log book and found two recent accidents had occurred at the practice. Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. The practice held a list of the medicines' expiry dates and had a procedure for replacing medicines. Staff knew where emergency medicines were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team where patients were vulnerable. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived. The practice had arrangements in place to manage emergencies. All staff had completed basic life support training and were able to tell us the locations of all emergency medical equipment and how it should be used.

Good

# Are services safe?

Emergency equipment was available including access to oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children.

Urgent appointments were available each day both within the practice and for home visits. We were told that the practice prioritised requests for urgent appointment for children. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record system in order for staff to summon help if needed. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. The document also contained relevant contact details to whom staff could refer. For example, contact details of the computer system supplier in the event of failure.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety risk assessment. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed the system had been maintained and tested.

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 were told by the GPs that the practice routinely used 'Medicine Map' which had up to date treatment protocols and referrals pathways which included the latest good practice guidance. 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 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 that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used their knowledge and patient records to identify patients with complex needs who had care plans documented in their case notes. We were shown the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients recently discharged from hospital were reviewed within 48 hours by their GP.

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**

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

The practice showed us several clinical audits that had been undertaken in the practice recently. We read an audit relating to the frequency of monitoring of patients who took methotrexate by regular blood tests. The practice re-audited and was able to demonstrate that the change in the testing frequency had not impacted on patients outcomes.

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). (The 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). The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 100% of patients with diabetes had an annual medication review, and the practice met all the minimum standards for the QOF in diabetes/asthma/chronic obstructive pulmonary disease (lung disease).

The team was making use of clinical audit tools, clinical supervision and staff meetings to monitor the performance of practice. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. For example, we saw an audit of patients with atrial fibrillation (a cardiac rhythm disorder) who had been prescribed a certain medicine. Following the audit, some patients had their medicine changed and additional monitoring put in place.

Staff spoke positively about the culture in the practice of involvement and how they could contribute to improvements to the service.

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice 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 participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area.

**Effective staffing**

Practice staffing included medical, nursing, managerial and administrative staff and a trainee physicians associate who, under the supervision of a GP, dealt with minor illnesses. We reviewed staff training records and saw that staff had completed mandatory courses such as annual basic life support. We noted a good skill mix among the doctors. We found that one GP had recently completed a course related to alcohol dependency through the Royal College of General Practitioners as this was a challenge within the practice patient group. 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 had an appraisal 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. We were told about the training offered to the nurses to allow them to extend their professional role. For example, the health care assistant had received additional training to be able to undertake smoking cessation clinics. The practice supported placement for medical students in conjunction with the Bristol deanery.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, Those with extended roles for assessing and monitoring long-term conditions such as asthma, COPD and diabetes were also able to demonstrate they had appropriate training to fulfil these roles.

**Working with colleagues and other services**

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from 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.

The practice was commissioned for the new enhanced service for emergency admission avoidance 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). The practice had a system to monitor follow-ups were documented and that no follow-ups were missed.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients, for example those with children on the at risk register. These meetings were attended by health visitors and decisions were documented in a shared care record.

**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 through the Choose and Book system. We were told the administrators also booked transport for patients when arranging hospital appointments. (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).

The practice had signed up to the electronic Summary Care Record and included information for patients about the

Good

# Are services effective?

## (for example, treatment is effective)

system on their website; however this is not available until March 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 to coordinate, document and manage patients' care. All staff were fully trained to use the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice was able to facilitate the transfer of patient notes electronically.

**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 GPs told us they supported patients to make their own decisions and documented this 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 compiling. These care plans were reviewed annually or frequently if changes in clinical circumstances dictated it. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff 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).

There was a practice policy for documenting consent for specific interventions. For example, for insertion of intrauterine contraceptive devices, the patient's consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure.

**Health promotion and prevention**

The practice had met with the local authority and the Clinical Commissioning Group to discuss public health and health promotion, and to share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness. We were told the practice population had a positive approach to their health which was illustrated by the patient involvement in research projects. The practice was a proactive participant in research programmes and was part of the Primary Care Research Network. Patients were participating in a range of research studies such as assessing the effectiveness of compliance and techniques of patients who used respiratory inhalers, which contributed to promoting health improvement.

It was practice policy to offer a health check with the health care assistant 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 the culture at the practice was to use their contact with patients to help maintain or improve mental, physical health and wellbeing. This was reflected by the information available to patients in the waiting room which had information boards dedicated to a specific subject. We also heard that staff took the opportunity to undertake health monitoring when patients attended for routine appointments. We were told that for 2014-15 the practice had undertaken 2000 health checks out of the 3000 patients who were eligible such as patients between 40 – 75 years or those with specific long term conditions. Patients were followed up with appropriate treatment or referral if they had risk factors for disease identified at the health check.

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 100% had received a check up in the last 12 months. The practice had also achieved 99.1% of the QOF targets related to health promotion such as identifying the smoking status of patients over the age of 16, the practice offered nurse-led smoking cessation clinics to these patients. 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 according to their needs.

Good

# Are services effective?

## (for example, treatment is effective)

The practice's performance for cervical smear screening was 85.6% which was higher than the national average. There was a policy to offer telephone reminders for patients who did not attend for cervical smear screening and the practice audited patients who do not attend and their reasons. There was also a named nurse responsible for following up patients who did not attend screening. The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. There was a clear policy for following up non-attenders by the named practice nurse.

The practice had developed links with young people's organisations and the local college. This was to engage younger patients and inform them of the service offered, for example, the practice hosted a visit from the local scout group to educate them about the practice. We were told the practice was sourcing a smart phone application so as to promote engagement with younger patients and share health promotion information.

Good

# Are services caring?

## Our findings

**Respect, dignity, compassion and empathy**

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey for 2013, a survey of 252 patients with a return rate of 51%. The evidence from all this 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 93% of patients felt that their overall experience was good or very good. 95% of respondents said the last GP they saw or spoke with was good at treating them with care and concern and 98%had confidence and trust in the last GP they saw or spoke to

Patients completed CQC comment cards to tell us what they thought about the practice. We received 36 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients stated they felt GPs took an interest in them as a person and overall impression was one of wanting to help patients. We were given many examples of the GPs taking additional time to ensure patients received the care they needed such as making contact with patients outside of normal working hours, contacting secondary medical services to ensure referrals were received and attended to and delivering patient medicine on their way home from work. All the patients we spoke with said they would recommend the practice.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. We observed disposable curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We observed that in the treatment rooms the curtains were located around the door not around the examination couch. This meant that practitioners had to stand by the door when patients were changing to allow them some privacy. 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 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 to keep patient information private. The reception desk was also separated from the waiting room. 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.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive 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, data from the national patient survey showed 90% of practice respondents said the GP involved them in care decisions and 93% felt the GP was good at explaining treatment and results which was above average compared to Clinical Commissioning Group area.

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 telephone translation services were available for patients who did not have English as a first language. We saw the website had a facility for translation of information.

We found that the 2% of the population identified as vulnerable had their own care plan. We were told that the GPs acted as the care coordinator for a number of patients, all the plans had been reviewed. We found this provided a continuity of care and support for the patient because GPs could recall their patients and the particular circumstances, for example, if there was any local support or care.

Good

# Are services caring?

**Patient/carer support to cope emotionally with care and treatment**

The patients and staff we spoke with on the day of our inspection and the comment cards we received gave examples of how the practice was caring towards its patients. We were given examples of how they felt they were treated as individuals and given the opportunity to be involved in their care. All of the patients we spoke with talked about the importance of the relationship they had with their GP and how supportive this was. For example, we were told by patients who had experienced emotional stress and distress of the kindness and empathy expressed by GPs.

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice had good links with specific services in the local area and we were told they attended various working groups which targeted known areas of deprivation such as the social isolation found in a rural area. The practice has a number of voluntary drivers who can assist patients to attend the practice for treatment. The GPs provide free medical assessments needed by the volunteers for insurance purposes for their role.

One of the staff acted as a carer's champion for the practice and the practice's computer system alerted GPs if a patient was also a carer. Therefore all carers were identified and sent relevant information about the monthly drop in clinic run by the local carer's organisation. The practice hosted representatives from statutory and voluntary agencies to these clinics to offer carers advice. The practice had a dedicated noticeboard where we found written information available for carers to ensure they understood the various avenues of support available to them. Pudding Pie Lane Surgery has staff who were registered as "dementia friends" and support staff to undertake training to be dementia champions.

Staff told us that if families had suffered 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.

Outstanding ☆

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

**Responding to and meeting people's needs**

We found the practice was responsive to 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.

The practice had recognised the needs of different groups in the planning of its services. For example, the leg ulcer clinic, the clinic held at the local extra care housing complex and the regular visits to a local nursing home. All of which enabled patients who were vulnerable and required support, to receive medical care. We were also told the practice had identified "expert patients" with diabetes who participate in a buddying scheme with other diagnosed diabetic patients to support self-management of their illness.

**Tackling inequity and promoting equality**

The practice had access to online and telephone translation services. The practice had their equality and diversity statement on their website. The practice provided equality and diversity training as part of the staff induction.

The premises and services had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The services for patients were on the ground floor; however there was lift access to the first floor.

**Access to the service**

The practice is open on Monday to Friday 8.30am – 6.30pm and pre-booked appointments are available on Tuesday mornings from 6.30am. The branch surgery is open each morning for pre-booked appointments. The practice does not provide out of hour's services to its patients, this is provided by Bris Doc information on the out-of-hours service was provided to patients. Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits. 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.

The practice operated an open access system for patients who requested an appointment. The practice had a policy of seeing all of the patients who requested an appointment even if this extended the time spent in surgery. Patients who contacted the surgery or turned up and were given an estimated time for their appointment. Patients told us they were aware that appointment times were not limited to ten minutes but lasted for however long was needed. This system was valued by patients although it meant that they may have to wait beyond the time they expected. Patients were made also aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The feedback we received from patients was that they were very happy with their access to appointments; we heard that it was sometimes difficult to get through by phone first thing in the morning, however, as long as people contact the surgery by 11:45am they could be assured of an appointment on the same day. The practice also has an online booking system for planned appointments.

The practice was part of a pilot scheme funded through the Prime Minister's Challenge Fund. This meant that patients registered with the practice could access GP appointments at the weekend, through another practice. The practice had a system for home visits whereby all requests for urgent home visits were received as requested but also the practice kept a weekly plan for home visits to patients who had difficulty attending the practice. This allowed the practice GPs to concentrate on the management of patients with chronic illness, which in turn linked to other projects such as the admission avoidance enhanced service, and ensured patients with these conditions had their care plan regularly reviewed.

Outstanding ☆

# Are services responsive to people's needs?

## (for example, to feedback?)

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. This also included appointments with a named GP or nurse. The patient record system had an alert which to indicate patients who required longer appointments. Home visits were made to a local specialist dementia care home alternately by two named GPs. The GPs did not have any additional qualification in dementia however they had an arrangement to access advice and support from the psycho geriatrician. A monthly GP clinic was also held at a local extra care housing complex.

Appointments were available outside of school hours for children and young people. Specialist clinics were arranged for childhood immunisations. We also found that the practice has prioritised vaccination against influenza for patients who met the criteria, for example, older patients and pregnant mothers.

**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 both in the practice and on the website. None of the patients we spoke with had ever needed to make a complaint about the practice. We looked at the complaints received in the last 12 months and found these were satisfactorily handle and dealt with in a timely way. The surgery had followed its own policy in handling complaints. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The practice took account of complaints and comments to improve the service, for example, complaints were discussed by the team so staff could contribute and learn. Information about how to complain was available in the waiting room and 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)

## Our findings

**Vision and strategy**

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. They had produced a Patient's Charter which highlighted personal doctoring and good communication as a key objective for the practice. The vision and practice values were that the practice believed in an individual doctor patient relationship, combined with the strength and depth provided by a group of doctors working together in a modern practice; good communication as the essence of good medicine and a successful "patient practice" relationship, and the practice strove to provide evidence-based, cost effective and up to date medical care for patients without prejudice and with compassion and empathy. We spoke with several 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 via any computer within the practice. We looked at the policies and procedures related to information governance. We saw the Data Protection information and noted the policy referred to the eight principles of data protection. The confidentiality policy informed the reader of how the practice operated to maintain patient information so as to protect confidentiality. Information on the practice website also informed patients about confidentiality and how patients can access their own records. The practice also had a policy to follow for patients who made freedom of information requests. Staff we spoke to confirmed these subjects were covered as part of their induction.

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice showed it was performing in line with national standards. We saw that QOF data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. The member of staff who monitored performance told us about the regular checks undertaken to ensure that patients had received the reviews and tests they needed. We were told that if there were any deficits then the GPs and nurses would be made aware of this and action to remedy the situation would be taken. We also discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services. For example, the '**Avoiding Unplanned Admissions' enhanced service meant the practice was proactive in identifying vulnerable patients, and ensured the care plans were in place and were reviewed.**

The practice had an ongoing programme of audits, clinical and non-clinical which it used to monitor quality and systems to identify where action should be taken. We read an audit of patients with hypertension and noted that medicines for some patients were changed which improved their optimal blood pressure control.

The practice held regular governance meetings. We looked at minutes from the last three meetings and found that performance, quality and risks had been discussed.

**Leadership, openness and transparency**

There was a GP and administrative staff leadership structure with named members of staff in lead roles. The staff we spoke with told us they 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. For example, the senior GP partner was the lead professional for safeguarding whilst another GP had responsibility for business development. We found there was a limit to the amount of time the partner who led in the business development had to oversee the management of the service. This had resulted in areas of the day to day running of the practice being delegated but not being monitored for effective management.

We saw from minutes that team meetings were held regularly, at least monthly, and staff shared a morning break so as to be available for any concerns or issues. 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.

**Seeking and acting on feedback from patients, public and staff**

The practice had gathered feedback from patients through patient surveys, comment cards and complaints received. The practice had an active patient participation group which included representatives from various population groups such as younger patients and those of working age.

# Are services well-led?

Good

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

The results and actions agreed from all surveys are available on the practice website. The practice also produced a quarterly newsletter available in the practice and on the website.

The practice had distributed a survey electronically to the virtual patient group and on the practice website. Paper copies were available from the practice during the survey period of January – February 2014. All patients were asked to complete the survey anonymously and to provide demographic data. The responses were collated along with the comments made by patients. For example, patients said that they would like the reception to be manned despite having the automated check in facility. This was agreed and implemented by the practice. The practice informed patients of actions and decisions through the newsletters.

The practice had gathered feedback from staff through meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

**Management lead through learning and improvement**

The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the North Somerset Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits and complaints. The practice was closed for training from 1.30pm monthly on the 3rd Wednesday. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan.

The practice was a GP training practice with one partner taking the lead for GP training. The ethos of the practice was that GPs in training brought new ideas and ways of working to the practice, and were able to challenge established practice. We spoke with the GP currently in training at the practice who was appreciative of the support and understanding provided by the practice.