Bradford on Avon & Melksham Health Partnership

Quality Report

Bradford on Avon Health Centre
Station Approach
Bradford on Avon
Wiltshire
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Tel: 01225 866611
Website: www.boamhp.co.uk

Date of inspection visit: 18 August 2016
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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

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 Bradford on Avon and Melksham Health Partnership on 18 August 2016. Overall the practice is rated as outstanding.

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

- The leadership and culture of the practice was used to drive improvements and deliver high quality person centred care. The practice undertook a systematic approach to work effectively as a whole practice team, involve the patients and the community and other organisations to deliver the best outcomes and deliver the care within the community wherever possible.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example the practice had introduced a wide range of initiatives over the past two years to support people; The 'Leg Club', a Memory Café, a balance and falls class, and set up a social hub in the local community.
- The practice used opportunities to improve outcomes where possible for example, during the flu clinic they checked patients over 65 for an irregular pulse and identified 24 new patients with atrial fibrillation (an irregular heart beat which led to identification of patients who may be have an increased risk of stroke and needed advice and/or medication).
- Feedback from patients about their care was consistently positive.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG). For example the PPG had contributed to producing a directory of self-care support groups,

raised awareness of key public health messages, conducting surveys and submitting proposals for improvements. The PPG had recently been involved in discussions on recruitment for new staff, including GPs.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- The practice actively reviewed complaints and how they are managed and responded to, and made improvements as a result.
- The practice had a clear vision which had quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- The practice had strong and visible clinical and managerial leadership and governance arrangements.

We saw several areas of outstanding practice including:

The practice provided a 'Leg Club', an innovative primary care led service to deliver research based wound management in a friendly social environment, provide staff development and learning, provide continuity of care and coordinated care, promote health and wellbeing and achieve outcomes and peer support. This service had improved outcomes for patients including reduced healing times, reduced recurrence rates (from 75% to 25%), improved social isolation, reduced house-bound contacts by 26% and reduced referrals to secondary care.

The practice employed an integrated team to drive forward the Transforming Care for Older People Team (TCOP) work programme who worked together to integrate the information technology systems to improve information sharing, break down barriers to effective communication and improve discharge planning and reduce admissions . The team undertook urgent home visits to enable a rapid service to those who may be at risk of an admission, the care coordinator visited patients in hospital prior to their discharge to facilitate their discharge and ensure the correct care was in place.

The practice offered seven day nurse support for local Nursing and Care homes, education support for staff in local Nursing and Care homes and access to wound care at the weekends in the local community.

The practice had responded to some concerns relating to delays accessing some mental health services for children and recognised that some needs were not fully met. The practice implemented regular meetings with the Health Visitors, introduced a mental health resource file for each consultation room with self-help material an assessment and support pack, and and created a mental health representative post to provide a contact for mental health patients (or their families) that need assistance.

The practice had an active patient participation group (PPG), they were very engaged in how the practice was run and had delivered health promotion sessions, contributed to producing a directory of self-care support groups and run volunteer support services.

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.

- There was an effective system in place for reporting and recording significant events which included identifying any areas where they could improve practice. The practice valued opportunities to discuss incidents in an open, blame-free culture, including what went well, positive points and to commend and acknowledge good practice.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Outstanding

The practice is rated as outstanding for providing effective services.

The practice had a holistic approach to assessing, planning and delivering care and treatment for their patients. They used innovative approaches to care and actively sought opportunities to deliver the care within the local community, involve the community and empower the patients to improve their outcomes. For example the practice during the last flu clinic checked patients over 65 for an irregular pulse and identified 24 new patients with atrial fibrillation (an irregular heart beat which led to identification of patients who may be have an increased risk of stroke and needed advice and/or medication).

The practice had focussed on the services in place after a diagnosis of dementia and provided a comprehensive one-stop-clinic for people living with memory problems. This led to improved diagnosis targets.

The practice developed a “lunch and learn” for staff training on dementia, which the practice shared across the whole region (which had been downloaded by over 100 practices).

Summary of findings

- Our findings at inspection showed that systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines.
- We also saw evidence to confirm that the practice used these guidelines to positively influence and improve practice and outcomes for patients.
- Housebound patients who are on insulin are visited by the community nursing team. They met regularly with the diabetic lead GP to adjust the patient's medicine, optimise control and reduce complications.
- Data showed that the practice was performing highly when compared to practices nationally. For example diabetes indicators showed that the practice was performing higher than local and national averages.
- The practice used innovative and proactive methods to improve patient outcomes and working with other local providers to share best practice.

Are services caring?

The practice is rated as outstanding for providing caring services.

Outstanding

- Data from the national GP patient survey showed 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. Many commented that staff went the extra mile and the care they receive exceeds expectations.
- People who used the services were active partners in their care. Staff empowered the patients to have a voice and contribute to their care.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

The practice is rated as outstanding for providing responsive services.

Outstanding

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example the practice had introduced a wide range of initiatives over the past two years including the' Leg Club', Memory Café and a balance and falls class.

Summary of findings

- There were innovative approaches to providing integrated patient-centred care. For example: the practice integrated care team worked in collaboration with Wiltshire Council on the 'Single View' project which aims to bring the information systems together to provide a single view of patients who are known to Adult Social Care which aims to avoid duplication and find out the patients story only once.
- The practice implemented a patient liaison officer role to specifically assist patients with home visit requests, community nurse visits and death notifications.
- The GPs observed that some patients were repeatedly booking multiple appointments, visiting the surgery on multiple occasions in a single day and impacting on the capacity for other patients. The practice undertook an audit to review the appointment reasons; from this a number of conditions were identified where patients needed extra support and early intervention. The practice recognised that many of these patients would benefit from a structured treatment plan to develop patient self confidence and self-esteem. This audit was shared with the clinical team. The practice introduced self-help care plans for a number of these patients and noted an improvement in 13 patients. The importance of an individualised patient centred approach was noted as key to engaged improved care.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group.
- Patients can access appointments and services in a way and at a time that suits them.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding

The practice is rated as outstanding for being well-led.

The leadership and culture of the practice was used to drive improvements and deliver high quality person centred care.

The practice undertook a systematic approach to work effectively as a whole practice team, involve the patients and the community and other organisations to deliver the best outcomes and deliver the care within the community wherever possible

Summary of findings

Governance and performance management arrangements are proactively reviewed and reflect best practice.

- The leadership of the practice valued continuous improvement and the whole practice was involved in delivering change and seeking out new ways of providing care.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. Staff were all encouraged to identify any areas where they could improve practice. Opportunities were taken to discuss incidents in an open environment and within a blame-free culture, including what went well, positive points and to commend and acknowledge good practice.
- High standards were promoted and owned by all practice staff and teams worked together across all roles. Staff were developed to maximise their potential, for example staff were encouraged to mentor new staff, encouraged to take ownership of projects and develop new ideas to the practice.
- 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, many staff told us they were encouraged to develop and they valued the learning culture of the practice and felt it was an environment where they were supported to grow.
- The practice gathered feedback from patients and it had a very engaged patient participation group (PPG) which influenced practice development. For example the PPG had produced a directory of self-care support groups, been involved in engaging the community in health and social care delivery of services including volunteer support at the 'Leg Club' the social 'Hub' in the community and recently become involved in discussions on recruitment.

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 The practice is rated as outstanding for the care of older people. The practice had introduced a wide range of initiatives over the past two years to support people at risk of social isolation and worked with the older person's forum and Age UK to offer a range of additional services to encourage people to learn new skills or attend social events. The practice employed an integrated team to drive forward the Transforming Care for Older People Team work programme. The practices' integrated team had worked together to integrate the information technology systems to improve information sharing, break down barriers to effective communication and improve discharge planning and reduce admissions. • All patients over the age of 75 have a named GP and care plans where required. • Patients who are in hospital including any who have attend A+E are reviewed and specific patients (for example following orthopaedic surgery or a fall) are visited by the care coordinator (including visiting during the hospital stay) and then followed up by a telephone call or a visit. • The practice has regular end of life meetings with local community teams and the local hospice, care plans are documented along with preferred place of death • The practice held a weekly ward round with 12 local Care Homes and regular nurse visits. The nursing team provided education sessions and support for the staff. The practice has delivered this service for the past three years and seen a 30% reduction on patients being admitted as an emergency from Care Homes. The practice worked with Age UK to roll out the 'Improving Access to Psychological Therapies' for older people.	**Outstanding**
People with long term conditions The practice is rated as outstanding for the care of people with long-term conditions. The practice worked with the older person's forum and the health and wellbeing board to develop social prescribing initiatives for people with long term conditions.	**Outstanding**

Summary of findings

The practice liaised with the Consultant Diabetologist and Diabetes Specialist Nurse for complex patients with diabetes for care and treatment reviews. Patients who are housebound with diabetes are reviewed yearly in their home.

The practice was actively involved in monitoring and improving outcomes for patients with long term conditions and had undertaken research studies including multiple diabetes studies, coronary heart disease and heart failure, asthma and COPD, vaccine studies and many other therapeutic areas.

- Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators were similar or above the local and national averages:
- The percentage of patients with diabetes, on the register, in whom the last blood test showed their blood sugar levels were in the target range (in the preceding 12 months 2014/15), was 85% which was higher than the CCG average of 82% and the national average of 78%.
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (2014/15) was 97% which was higher than the CCG average of 91% and the national average of 88%.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

The practice is rated as outstanding for the care of families, children and young people.

Outstanding

- The practice had developed a young persons assessment and support pack for young patients and had made links with the local school and the youth club to offer assistance and advice and to promote the surgery and services available to them.
- The practice developed a range of booklets following an audit of the information available to patients relating to long term contraception advice; these had been shared with other practices. The practice offers a range of contraceptive and emergency contraceptive services.

Summary of findings

- The practice offers a comprehensive 'No Worries' service which is confidential and includes a 'condom service', this is available for patients up to 24 years of age whether they are registered at the practice or not.
- A Health Visitor works at the surgery on a Monday and has a liaison meeting with the lead family GP to discuss concerns, safeguarding and complex patients.
- Parents with addictive behaviours are also identified on the child record with a specific patient identifier.
- The Friends and Family Test was extended to gain the views of children.
- Appointments were available with the emergency GP or a Nurse Practitioner at the end of the school day to support parents and children who need an appointment – double appointments were available if requested.
- The practice asked at patient registration if a young person was a carer to sign post to support and activities that may help them. There was information on a carers information board aimed at young carers, a tailored leaflet for young carers and access to support and other services.
- A maternity pack was available for collection for the newly-pregnant mums. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations.
- We saw positive examples of joint working with midwives, health visitors and school nurses including weekly sessions in a dedicated medical centre at two local boarding schools, working alongside the school nurses.

Working age people (including those recently retired and students)

Outstanding

The practice is rated as outstanding for the care of working-age people (including those recently retired and students).

The practice offered a range of on line services and a range of telephone consultations for people unable to visit the surgery for work reasons.

The practice took part in a pilot to increase the uptake of health checks which was entered into the Public Health Awards for innovation, the practice put on extra sessions in the evenings for a three month period and increased attendance by follow up phone calls.

Summary of findings

The practice had a range of health promotion and advice leaflets also on the website with links to external support, including referrals to weight management, exercise on prescription and other self-help options. The practice held a 'Topic of the Month' health promotion initiative in the practice and on the website.

• The practice offered early morning clinics.

• The practice offered minor operations delivered in-house.

People whose circumstances may make them vulnerable

Outstanding

The practice is rated as outstanding for the care of people who circumstances may make them vulnerable.

- The practice had a register of people deemed vulnerable to hospital admission; there were over 400 on the list who were sent a letter offering them a range of enhanced services within the surgery.
- The practice offered a rapid home visit service and emergency slots for vulnerable people with enhanced needs such as dementia and health anxiety.
- The practice had a list of people registered with a learning disability (LD) and all were offered an annual health assessment with joint health care planning. We saw 94% had had their health review in 2014/15. The practice attended the LD home regularly and supported carers with ad hoc visits and requests.
- The practice held quarterly and ad hoc vulnerable adult multidisciplinary meetings and safeguarding meetings. The practice had a safeguarding lead for children who had regular meetings with the health visiting team.
- The practice had a process in place to register people with no fixed abode and access treatment from a doctor or nurse.
- The practice had set up links to the social 'Hub' and provided a signatory for foodbank vouchers.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- 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)

Outstanding

The practice is rated as outstanding for the care of people experiencing poor mental health (including people with dementia).

Summary of findings

The practice had focussed on the services in place after a diagnosis of dementia and provided a comprehensive one-stop-clinic for people living with memory problems.

The practice had responded to some concerns relating to delays accessing some mental health services for children and recognised that some patient's needs were not being fully met. The practice implemented regular meetings with the Health Visitors to discuss individual children and families, ensured Health Visitor clinics at the practice on a Monday morning, introduced a mental health resource file for each consultation room with self-help material and created a mental health representative post to provide a contact for mental health patients (or their families) that need assistance.

Talking Therapies counselling support were available in the practice.

The practice had three dementia champions who delivered dementia friends training to the staff. The practice worked with the secondary care memory services and jointly reviewed complex patients. Patients were discussed with the multidisciplinary team, given a care plan involving their carers and offered support.

The practice had been accredited as dementia friendly, they were a partner of the Bradford on Avon Dementia Alliance Action Group which met quarterly and is collaborating on the 'Safe-Place' initiative and becoming a dementia friendly town.

- Performance for mental health related indicators were in line or higher than the local and national averages:
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (2014/15) was 93% which was higher than the CCG average of 88% and the national average of 84%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

Summary of findings

What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above the national averages. The national GP survey distributed 221 forms and 128 were returned. This represented less than 1% of the practice's patient list.

- 81% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 86% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 93% of patients described the overall experience of this GP practice as good compared to the national average of 85%.
- 90% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 78%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 61 comment cards which were all very positive about the standard of care received. Comments reported excellent care, compassion and sensitive, informative treatment, many comments noted how friendly all the staff groups were across the whole practice team.

We spoke with six patients during the inspection. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

Data from the national Friends and Family test showed that over the last year (August 15 to July 2016) 85% of patients were either extremely likely or likely to recommend this practice to their family and friends. The last three months May to July 2016 the data showed 92% to 90% would be extremely likely or likely to recommend this practice to their family and friends.

Outstanding practice

The practice provided a 'Leg Club', an innovative primary care led service to deliver research based wound management in a friendly social environment, provide staff development and learning, provide continuity of care and coordinated care, promote health and wellbeing and achieve outcomes and peer support. This service had improved outcomes for patients including reduced healing times, reduced recurrence rates (from 75% to 25%), improved social isolation, reduced house-bound contacts by 26% and reduced referrals to secondary care.

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Summary of findings

The practice had an active patient participation group (PPG), they were very engaged in how the practice was run and had delivered health promotion sessions, contributed to producing a directory of self-care support groups and run volunteer support services.

Bradford on Avon & Melksham Health Partnership

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP specialist adviser, a second CQC inspector, a CQC pharmacist and a practice manager specialist adviser.

Background to Bradford on Avon & Melksham Health Partnership

Bradford on Avon and Melksham Health Partnership was formed in 2011; the practice has four locations, two in the town of Bradford on Avon, one in the nearby village of Winsley and one location in the town of Melksham. The practice serves a population of approximately 21,350 patients and is in an area with low social deprivation.

The practice population has lower than average numbers of under 10 year olds, low numbers of patients between the ages of 20 to 40, and higher than the local and national averages of over 60s particularly those over the age of 85. The practice serves the third densest population area in Wiltshire. The practice in Melksham has seen a steady increase in patients joining the practice with approximately 30 patients joining each month.

The practice has nine GP partners with a tenth joining in April 2017 and two GP Associates. The GPs are supported by a team of emergency nurses, practice nurses, health care assistants, an integrated care nurse, a care coordinator and a practice pharmacist. The clinical team are supported by a team of administration, reception and dispensing staff, a General Manager, Business Manager and a managing partner.

The practice is a training practice and supports a number of Registrars (Registrars are qualified doctors who undertake additional training to gain experience and higher qualifications in general practice and family medicine).

The practice has four sites, with a dispensary at the Winsley site offering pharmaceutical services to those patients on its practice list who live more than one mile (1.6km) from their nearest pharmacy premises. The practice dispensed medicines for approximately 3,000 patients and was signed up to the Dispensing Services Quality Scheme, which rewards practices for providing high quality services to patients from their dispensary.

The practice was open at the following times:

The Health Centre, Bradford on Avon, 8.30am to 6pm.

St Margaret's Surgery, Bradford on Avon, 8.30am to 5.30pm.

Winsley Health Centre, 8.30am to 1pm and 2pm to 6pm.

St Damian's Surgery, Melksham, 8.30am to 6pm.

When the practice is closed the Out Of Hours care is provided by Medvivo accessed via NHS 111.

The practice services could be accessed from:

The Health Centre, Bradford on Avon,

Station Approach, Bradford on Avon, BA15 1DQ.

St Margaret's Surgery, Bradford on Avon,

29 Bridge Street, Bradford-on-Avon,

Detailed findings

Wiltshire, BA15 1BY

Winsley Health Centre, Nr. Bradford on Avon,

73a Tyning Road, Winsley,

Wiltshire, BA15 2JW.

St Damian's Surgery,

Spa Road, Melksham,

Wiltshire, SN12 7NZ.

During our inspection we visited the Health Centre at Bradford on Avon, the Winsley Health Centre and the St Damian's Surgery. We did not visit the St Margaret's Surgery.

The practice has a General Medical Services contract to deliver health care services. This contract acts as the basis for arrangements between NHS England and providers of general medical services in England.

Bradford on Avon & Melksham Health Partnership was not inspected under the previous inspection regime.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. The 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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 18 August 2016. During our visit we:

- Spoke with a range of staff including ten GPs, five of the nursing team, four of the management team, and a number of reception, administration and dispensing staff. We spoke to three members of the patient participation group and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- 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 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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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.

Good

Are services safe?

Our findings

Safe track record and learning

There was an effective system in place for reporting and recording significant events. The practice had recently reviewed and updated their significant event process to ensure they recorded any incident or situation that had the potential to prompt action, learning or change. A comprehensive process, proforma, flow chart and supporting policies were in place to support the staff.

- Staff told us they would complete a significant event record form and report any incidents to their nominated member of staff, there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- We saw evidence that when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.
- The practice carried out a thorough analysis of the significant events. This included identifying any areas that the team could learn from. Discussions took place within an open, no blame culture and actions were taken to improve practice.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. Alerts from the Medicines and Healthcare products Regulatory Agency were cascaded and actioned through the practice. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, the practice reviewed an incident where a patient with chest pain was rapidly identified by the receptionist as requiring intervention. The practice discussed what had happened including what went well. Staff were able to share similar situations. The practice implemented a 999 Ambulance procedure and updated their chest pain procedure.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs were trained to child protection or child safeguarding level three, nursing staff were trained to level two or three.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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 maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. An emergency nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control reports were undertaken and six monthly infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result. For example clinical rooms had introduced wall storage for gloves and wipes, a cleaning schedule was in place for the toys and fabric chairs were being replaced.
- The arrangements for managing medicines, including emergency medicines and vaccines kept patients safe (including obtaining, prescribing, recording, handling, storing and security). There were systems in place to monitor the temperature of all the fridges and areas

where medicines were stored, and all medicines were secure. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams and their own practice pharmacist, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer certain vaccines and medicines against a patient specific prescription or direction from a prescriber.

- Processes were in place for handling requests for repeat prescriptions which included the review of high risk medicines. Protocols were currently under review to further improve patient safety.
- There was a named GP responsible for the dispensary and all members of staff involved in dispensing medicines had received appropriate training and had opportunities for continuing learning and development. We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Any medicines incidents or 'near misses' were recorded for learning and was supported by a robust standard operating procedure. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.
- Dispensary staff showed us a comprehensive and up to date range of standard procedures which covered all aspects of the dispensing process (these are written instructions about how to safely dispense medicines). These were up to date and accurately reflected current practice. The dispensing process was safe and effective. The practice signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained.
- The practice established a delivery service for patients who were less mobile and had systems to monitor how these medicines were managed. They also provided a safe monitored dosage system for a local nursing home.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential for misuse) and had procedures to manage them safely. There were also arrangements for the appropriate destruction of controlled drugs.
- We reviewed five personnel files and found 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. The practice had up to date fire risk assessments and carried out regular fire drills (the last fire drill was in June 2016). All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice regularly reviewed and audited demand for appointments and the different needs of the patients and adjusted the appointments to meet these needs. For example the practice had increased the number of on the day appointments with emergency nurses which had increased urgent access to nurse and GP appointments and received positive feedback from patients.

Arrangements to deal with emergencies and major incidents

The practice had good arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.

Good

Are services safe?

- All staff received annual basic life support training and there were emergency medicines available in the consulting room.
- The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Outstanding

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice had a holistic approach to assessing, planning and delivering care and treatment for their patients. They used innovative approaches to care and actively sought opportunities to deliver the care within the local community and involve the community and empower the patients to improve their outcomes.

Examples include: the practice had set up a 'Leg Club' to deliver research based wound management in a friendly social environment. This had provided staff development, continuity and coordinated care for patients, promoted health and wellbeing and peer support. This service had improved outcomes for patients including reduced healing times, reduced recurrence rates (from 75% to 25%) and improved social isolation. The service had reduced house-bound contacts by 26% and reduced referrals to secondary care. The 'Leg Club' also expanded to provide podiatry, dementia advice, a balance and falls group, a walking group and an art group in a community setting. The success of the 'Leg Club' model had been shared across the clinical commissioning group (CCG) and neighbouring CCGs. It had also been presented at national events and published in national wound care literature.

The practice had focussed on the services in place following a diagnosis of dementia. A comprehensive one-stop-clinic for people living with memory problems was provided for patients at the practice. This had improved the diagnosis targets.

The practice used opportunities to improve outcomes where possible for example, during the flu clinic they checked everyone over 65 for an irregular pulse and identified 24 new patients with atrial fibrillation (an irregular heart beat which led to identification of patients who may be have an increased risk of stroke and needed advice and/or medication).

The practice developed a "lunch and learn" session on dementia, which the practice shared across the region. The practice shared the session through the internet so other practices could share the learning for staff.

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The whole practice team were engaged in activities to improve quality and outcomes for patients.

We saw high levels of commitment to working collaboratively and supporting the delivery of coordinated care and ensuring patients outcomes were a priority. The practice employed an integrated team to drive forward the Transforming Care for Older People Team (TCOP) work programme. This consisted of a care co-ordinator, project administration, care homes nurse and a nurse practitioner for acute home visits for the over 75s. The nurse practitioner undertook urgent home visits to enable a rapid service to those who may be at risk of an admission, the care coordinator visited patients in hospital prior to their discharge to facilitate their discharge and ensure the correct care was in place.

The practice's integrated team had worked together to integrate the information technology systems to improve information sharing, break down barriers to effective communication and improve discharge planning and reduce admissions. We saw a number of examples of improved outcomes through integrated working, for example a patient who had requested support from the GPs daily had (through the integrated teams involvement) regained control over their own care needs and improved the quality of life and engagement with their community.

The practice liaised with a Consultant Diabetologist and diabetes specialist nurse for patients with complex diabetes by email and telephone calls. For housebound patients on insulin a GP met with the District Nurse every few weeks to discuss each patient's blood glucose levels

titrate their insulin according to their clinical need, to improve safety, reduce admissions and reduce complications. We saw evidence of improved outcomes for all the seven patients this affected.

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 100% of the total number of points available. The practice had an overall exception rate of 6.6% which was lower than the local average of 11.2% and the national average of 9.1%. The practice data showed the practice was not an outlier for any QOF (or other national) clinical targets. The data showed that the practice had very low numbers of patients excepted for dementia (3% compared to the national average of 8%), diabetes, cancer and the practice had only excepted one patient (0.8%) across all mental health indicators. The only exception rates higher than the local and national averages were in heart failure and cervical screening for example; We looked into this during the inspection and found that the follow up system in place and care was appropriate.

Data from 2014/15 showed:

- The percentage of patients with hypertension (high blood pressure) in whom the last blood pressure reading measured in the preceding 12 months was in the target range was 89% which was higher than the CCG average of 85% and the national average of 84%.
- The percentage of patients with diabetes, on the register, in whom the last blood test showed their blood sugar levels were in the target range (in the preceding 12 months 2014/15), was 85% which was higher than the CCG average of 82% and the national average of 78%.
- The percentage of patients on the diabetes register, with a record of a foot examination and risk classification within the preceding 12 months (2014/15) was 97% which was higher than the CCG average of 91% and the national average of 88%.
- The percentage of patients with a serious mental health problem who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months (2014/15) was 93% which was the same as the CCG average of 93% and higher than the national average of 88%.
- The percentage of patients with a serious mental health problem whose alcohol consumption has been recorded in the preceding 12 months (2014/15) was 97% which was higher than the CCG average of 93% and the national average of 90%.
- The percentage of patients diagnosed with dementia whose care has been reviewed in a face-to-face review in the preceding 12 months (2014/15) was 93% which was higher than the CCG average of 88% and the national average of 84%.

There was evidence of quality improvement including clinical audit.

- There had been nine clinical audits completed in the last two years, four of these were completed audits where the improvements made were implemented and monitored.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. The practice held weekly clinical research update meetings with the research team.
- The practice held regular updates for the doctors and nurses on the current studies the practice was participating in and regular meetings with the study teams of each study to review recruitment, performance, and adherence to protocols and ongoing review of the study.
- The practice research team attended local and international meetings relating to the research studies to ensure best practice and held regular meetings with the clinical research network for regular updates and training
- The practice was actively involved in monitoring and improving outcomes for patients with long term conditions and had undertaken numerous research studies including multiple diabetes studies, coronary heart disease, asthma and COPD, vaccine studies and many other therapeutic areas.
- Findings were used by the practice to improve services. For example following an audit into diabetes control for certain patients on medication, the clinical team introduced tailored care plans to optimise their diabetes care, since the introduction of the care plans a reduction in admissions had been seen. For example one patient had had five admissions with diabetic

Outstanding

Are services effective?

(for example, treatment is effective)

problems and multiple paramedic visits in the year before the shared care project but no diabetes related admissions since. Improvements had been seen in all the seven patients involved in this project.

Information about patients' outcomes was used to make improvements such as: following updated NICE guidance relating to the criteria for below knee compression following a deep vein thrombosis (a blood clot in the leg), the practice audited patients and found that not all eligible patients were receiving the optimum care, this highlighted an improvement needed which the practice then raised with the CCG.

Effective staffing

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality. New staff confirmed they felt very well supported through their induction and all staff were helpful and supportive.
- The practice was a training practice and conducted regular tutorials, and delivered a weekly programme of education, including topics delivered by visiting consultants and in-house meetings. For example updates in respiratory care, palliative care, safeguarding and changes to the Health and Social Care Act.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions staff had undertaken updates in wound care, diabetes management, and many other long term conditions. We saw a comprehensive training programme for the nursing staff. For example, trauma care, advance life support, mandatory updates, two nurses had recently completed child safeguarding level three, and two nurses had completed their nurse prescribing course.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by attending courses, mentoring support, access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating nurses and GPs. The GPs and nurses all had support from a mentor. All staff had received an appraisal within the last 12 months.
- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals on a monthly basis when care plans were routinely reviewed and updated for patients with complex needs.

Consent to care and treatment

Staff sought patients' consent to care and treatment in line with legislation and guidance.

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005. When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice had undertaken a pilot with Wiltshire Council last year, to test the barriers to patients attending for a NHS Health Check and improve uptake. The practice provided additional Monday evening appointments and additional health check appointments at its branch site, St Damian's Surgery, to encourage those patients who were working and had previously declined a health check to attend. The practice followed up those who did not respond to the health check offer and raised the attendance over the four months. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Each month the practice had a 'topic of focus' for health education and/or health promotion. Topics included health check promotion, earwax treatments, cervical screening promotion and smoking cessation support. The monthly topics were supported by extra information in the waiting area, on the practice website and in the practice newsletter.

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and/or alcohol cessation. The practice offered a range of support services including access to social services support through the local 'social Hub', walking groups, health promotion advice, memory cafes, an arts club, the 'Leg Club' and a falls and balance group.

The practice's uptake for the cervical screening programme was 79%, which was comparable to the CCG average of 77% and above the national average of 74%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer screening. The practices uptake for the breast screening programme was 76% which was comparable to the CCG average of 77% and higher than the national average of 72%. The practices uptake for the bowel screening programme was 65% which was above the CCG average of 63% and the national average of 58%. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results.

Childhood immunisation rates for the vaccines given were comparable to CCG averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 84% to 99% compared to the CCG range from 83% to 98% and five year olds from 91% to 96% compared to the CCG range from 92% to 97%.

Outstanding

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted that consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 61 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with three members of the patient participation group. They also told us they were very satisfied with the care provided by the practice and said their dignity and privacy was respected. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

Results from the national GP patient survey showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 95% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 91% of patients said the GP gave them enough time compared to the CCG average of 90% and the national average of 87%.
- 95% of patients say the last nurse they saw or spoke to was good at giving them enough time compared to the CCG average of 94% and the national average of 92%.
- 98% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 97% of patients had confidence and trust in the last nurse they saw or spoke to compared to the CCG average of 98% and the national average of 97%.
- 95% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and the national average of 85%.
- 95% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 91%.
- 97% of patients said they found the receptionists at the practice helpful compared to the CCG average of 90% and the national average of 87%.

Data from the national Friends and Family test showed that over the last year (August 15 to July 2016) 85% of patients were either extremely likely or likely to recommend this practice to their family and friends. The last three months May to July 2016 the data showed 92% to 90% would be extremely likely or likely to recommend this practice to their family and friends.

Care planning and involvement in decisions about care and treatment

Patients told us 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

Results from the national GP patient survey showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and above national averages. For example:

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and the national average of 86%.

Outstanding

Are services caring?

- 86% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 82%.
- 91% of patients say the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 87% and the national average of 85%.

The practice provided facilities to help patients be involved in decisions about their care:

- Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- Patients we spoke to all confirmed they were involved in decisions about their care.

Patient and carer support to cope emotionally with care and treatment

The practice had initiated a patient liaison officer role, who was available at the practice to specifically assist patients with home visit requests, community nurse visits and death notifications.

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations, the practice had involved the patients in proof reading the leaflets to ensure the information was relevant and accessible for the patients. Information about support groups was also available on the practice website.

The practice had won the Wiltshire Carers Gold award for support for carers.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 541 patients as carers (2.5% of the practice list). The practice had a carer's information board, information in leaflets and the website and support from staff to direct carers to the various avenues of support available to them. The practice asked at patient registration if a young person was a carer to sign post them to support and activities that may help them. There was information on a carers information board aimed at young carers, a tailored leaflet for young carers and access to support and signposting to other services.

Staff told us that if families had suffered bereavement, their usual GP contacted them or sent them a sympathy card. 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

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and clinical commissioning group (CCG) to secure improvements to services where these were identified. Examples of innovative care to improve outcomes for patients included:

- The practice had introduced a wide range of initiatives over the past two years to support people including the 'Leg Club', a Memory Café, a balance and falls class and worked with the older person's forum and Age UK to offer a range of additional services to encourage people to learn new skills or attend social events.
- The practice had responded to concerns relating to delays in accessing some mental health services for children and recognised that some needs were not fully met. The practice implemented regular meetings with the Health Visitors, introduced a mental health resource file for each consultation room with self-help material and created a mental health representative post to provide a contact for mental health patients (or their families) that need assistance.
- Seven day nurse support for local Nursing and Care homes. Education support for staff in local Nursing and Care homes.
- Access to wound care at the weekends in the local community.
- Joint visits with nursing staff and social care staff to ensure a holistic assessment of patients' needs for housebound patients with complex needs.
- Liaison with the diabetes foot clinic and Tissue Viability nurse when indicated for diabetes foot problems and ulcers
- Telephone consultations and blood glucose/medicine reviews for patients with diabetes in the evening when needed, additionally Insulin reviews and titration phone calls as needed by patients.
- The practice offered a rapid home visit service and emergency slots for vulnerable people with enhanced needs such as dementia and health anxiety.
- The practice welcomed the boating community and provided a range of benefits for staff from this community including a shower, bike rack, flexible working and the ability for patients from the boating community to have their medical post delivered to the practice. This initiative had been highlighted as good practice by the press and the Bath and North Somerset Community Engagement Manager.
- Talking Therapies counselling support is available at the practice.
- The practice recently received PREVENT training (training to help identify and raise awareness relating to radicalisation) form the local police liaison service as well as additional sessions on the Mental Capacity Act and Best Interests.
- The practice integrated team worked in collaboration with Wiltshire Council on the 'Single View' project which aims to bring the information systems together to provide a single view of patients who are known to Adult Social Care which aims to avoid duplication and find out the patients story only once.
- The Friends and Family Test was extended to gain the views of children.
- The practice delivered dementia screening during diabetes clinics.
- Retinal screening was available at St Margaret's Surgery, Bradford on Avon.
- The practice had three dementia champions who delivered dementia friends training to the staff. The practice worked with the secondary care memory services and jointly reviewed complex patients. Patients were discussed with the multidisciplinary team, given a care plan involving their carers and offered support.
- The GPs observed that some patients were repeatedly booking multiple appointments, visiting the surgery on multiple occasions in a single day and impacting on the capacity for other patients. The practice undertook an audit to review the appointment reasons; from this a number of conditions were identified where patients needed extra support and early intervention. The practice recognised that many of these patients would benefit from a structured treatment plan to develop patient self confidence and self-esteem. This audit was shared with the clinical team. The practice introduced self-help care plans for a number of these patients and noted an improvement in 13 patients. The importance of an individualised patient centred approach was noted as key to engaged improved care
- There were longer appointments available for patients with complex needs and/or a learning disability.

Outstanding

Are services responsive to people's needs?

(for example, to feedback?)

- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Following the closure of the children's centre in Bradford on Avon and the centralisation of services in Melksham which reduced the availability of services locally for patients, the practice had liaised with the Health Visitors and other providers to arrange services locally and worked with other providers to deliver the services in local buildings.
- There were disabled facilities, a hearing loop and translation services available.

Access to the service

The practice was open at the following times:

The Health Centre, Bradford on Avon, 8.30am to 6pm (with telephone access until 6.30pm and 7.30pm on Tuesdays)

Appointments are offered between 8.30am to12.30pm and 2pm to 6pm, with extended hours until 8pm on Monday evenings.

St Margaret's Surgery, Bradford on Avon, 8.30am to 5.30pm (with telephone access 8.30am to 12.30pm and 2pm to 5.30pm), appointments are offered between 8.30am to12.30pm and 2pm to 5pm.

Winsley Health Centre, Winsley, 8.30am to 1pm and 2pm to 6pm (telephone access the same)

Appointments are offered between 8.30am to 12.30pm and 2pm to 6pm, with extended hours on Thursday evenings until 7.30pm for telephone consultations.

St Damian's Surgery, Melksham, 8.30am to 6pm (with telephone access 8am to 6.30pm)

Appointments are offered between 8.30am to12.30pm and 2pm to 6pm with, extended hours on Monday evenings until 8pm.

In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for people that needed them.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 78% of patients were satisfied with the practice's opening hours compared to the CCG average of 77% and the national average of 76%.
- 81% of patients said they could get through easily to the practice by phone compared to the CCG average of 80% and the national average of 73%.
- 66% of patients usually get to see or speak to their preferred GP compared to the CCG average of 64% and the national average of 59%.

People told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

The practice had a comprehensive triage system to review any urgent requests and offer phone advice, consultations or visits as required. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

Listening and learning from concerns and complaints

The practice had an effective 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.

We looked at two complaints received in the last 12 months and found these were satisfactorily dealt with in a timely way with openness and transparency. Lessons were learnt from individual concerns and complaints and also from analysis of trends and action were taken to as a result to improve the quality of care. For example, following a complaint relating to the customer service of a receptionist the practice had delivered customer service training for staff and shared the learning across the practice team to reduce the likelihood of any reoccurrence.

Are services well-led?

Outstanding

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

Our findings

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

Our findings

The leadership and culture of the practice was used to drive improvements and deliver high quality person centred care. The practice undertook a systematic approach to work effectively as a whole practice team, involve the patients and the community and other organisations to deliver the best outcomes and deliver the care within the community wherever possible.

We saw very high levels of staff satisfaction, many staff told us they were encouraged to develop and grow and many staff told us they valued the learning culture of the practice and felt it was an environment where they were supported to grow.

Vision and strategy

The practice had a clear vision to ensure the highest standard of family care and to offer patients continuously improving and appropriate access to health care professionals.

The practice had a mission statement and staff knew and understood the values.

- The leadership of the practice valued continuous improvement and the whole practice was involved in delivering change and seeking out new ways of providing care.
- The practice valued staff engagement and the involvement and integration of the local community.
- The practice had a detailed succession planning in place including utilising opportunities for the administration and management workforce and up-skilling staff where possible, for example the patient liaison role.
- The practice had written an article published in national medical journals about retaining the workforce.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured that:

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. Staff were developed to maximise their potential, for example staff were encouraged to mentor new staff, encouraged to take ownership of projects and develop new ideas to the practice.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were robust arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. Staff were all encouraged to identifying any areas where they could improve practice. Opportunities were taken to discuss incidents in an open environment and within a blame-free culture, including what went well, positive points and to commend and acknowledge good practice.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).This included support training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure that when things went wrong with care and treatment::

- The practice gave affected people reasonable support, truthful information and a verbal and written apology

Are services well-led?

Outstanding

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

- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported and valued by management.

- Staff told us the practice held regular team meetings. The practice had ensured the involvement of staff across the different locations by using technology so staff from the different sites could engage with staff meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients, the public and staff. It proactively sought patients' feedback and engaged patients in the delivery of the service. The practice had an active patient participation group (PPG), they were very engaged in how the practice was run and encouraged to look for opportunities for improvements.

For example the PPG and the practice had reviewed the National Association for Patient Participation document "Growing Patient Participation - 21 Ways to help your practice thrive". From this the PPG had identified a number of actions including; Sharing good practice by networking with other PPGs, organising presentations on important health needs, producing a directory of self-care support groups, raising awareness of key public health messages, running volunteer support services, conducting surveys and submitting proposals for improvements. The PPG had recently been involved in discussions on recruitment for new staff.

The practice delivered a number of health education and information sessions including: Why does the receptionist ask 'some idea of the question', dementia awareness, going green/sustainability in the surgery, breast cancer awareness and osteoporosis.

The practice had introduced a tailored Friends and Family test for children to gain children's feedback. They had 59 respondents and from the feedback introduced changes including laminated fun puzzles for children in the waiting rooms, increased the monitoring of the toilets cleanliness and updates by receptionist to notify patients of delays where possible.

The practice encouraged feedback from staff 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, for example the nursing team submitted feedback and evidence of the value of using two trained nurses for immunisation clinics due to the increase in the childhood immunisation programme, the GPs and management team recognised the value of this feedback and supported the change the nurses recommended. Staff told us they felt involved and engaged to improve how the practice was run.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area.

The practice had a number of awards which recognised its innovation and commitment to improvement including:

Joint Bronze award for its Going Green Sustainability project (July 2015) and joint overall winner for Green Impact for Health pilot 2015.

The awards received in 2016 for the Leg Club:

• LCIP European Wound Management Association 2015, London scholarship award.

• The Leg Club Foundation - Volunteers of the Year Award.

• Public Health Awards for 'Innovations in Health Improvement.'

• General Practice Awards for clinical team of the year in Dermatology.

National NHS England Friends and Family Test Award for Primary Care.

• Short-Listed for the Nursing Times Award - Innovation in Health Care.

Are services well-led?

Outstanding

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

The practice employed a practice pharmacist for 20 hours per week to support the GPs and prescribing clerks, as well as review patient queries. The pharmacist aims include; improve quality, improve prescribing, reduce polypharmacy, support long term conditions and reduce waste.

The practice had a comprehensive practice development plan which included looking at the future capacity and sustainability of the service, the resilience of the practice, future expansion, ways to use information and technology to support primary care for example mobile working.

The practice had a locality manager for projects including a falls clinic, the development of a 'Leg Club' in Melksham, a health and wellbeing fair, working with the health and wellbeing board and Age UK to support older people and social prescribing initiatives.

The practice recognised the challenges to primary care including the secondary care pressures and difficulty accessing services (for example physiotherapy, pain management, dermatology, mental health and emotional distress services); the practice was looking for innovative ways to help deliver the optimum care for the patients in the local community. For example the practice was working with Age UK to roll out the 'Improving Access to Psychological Therapies' for older people, developing a befriending service in Bradford on Avon, with volunteers from the local community; as well as the development of time-banking, a national initiative which aims to give people a chance to help others in a managed way and thus improving self-esteem, making friends and helping the community.

The practice was developing an action plan to review patients who may be on a medicine for memory loss without a diagnosis of dementia, people in care homes known to have dementia but not formally diagnosed and a review people diagnosed with a mild cognitive impairment. The plan is to be shared with the CCG.

The practice had three dementia champions and 80% of their staff are now dementia friends. The surgery was working with the area board, the health and wellbeing board and the Dementia Alliance to develop a dementia friendly town, along with a 'Safe-Place' initiative. There are further plans being developed to create extra Memory Café sessions across the summer at a local public house.

The practice developed a range of booklets following an audit of the information available to patients relating to long term contraception advice; these had been shared with other practices.