Blackbrook Surgery

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We commenced an announced visit on 13 November 2014 but had to postpone our inspection due to a power failure. We returned to complete our inspection on 10 December 2014. We inspected Blackbrook Surgery as part of our new comprehensive inspection programme.

Overall we found the practice is rated as good. We saw many examples of a safe, effective, caring, responsive and well led practice. Patients reported high levels of satisfaction with the practice during our inspection and this was reflected in the comment cards we also received.

Our key findings were as follows:

- Staff understood their responsibilities to raise concerns and to report incidents to staff with lead responsibility in these areas. Lessons were learned and communicated to support improvement. Information about safety was recorded, monitored appropriately, reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.
- Systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence (NICE) guidelines and locally agreed guidelines. We saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data from the most recent Quality Outcomes Framework (QOF) showed that the practice was performing in line with neighbouring practices in the clinical commissioning group (CCG). The practice was using a range of methods to improve patient outcomes and it linked with other local providers in the Taunton and Deane Federation to share best practice.
- Data from the most recent 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. We also saw staff treated patients with kindness and respect and maintained confidentiality.
- The practice reviewed the needs of its local population and engaged with key organisations to secure improvements to services. Patients said they found it easy to make an appointment with a named GP and

Summary of findings

that there was continuity of care, with urgent appointments available the same day. The practice had appropriate facilities and was suitably equipped to treat patients and meet their needs.

- The practice had a clear vision which had been produced with stakeholders and was regularly reviewed and discussed with staff. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. There was constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using available technology, and it had a virtual patient participation group.

We saw areas of outstanding practice including:

- The practice kept a record of 'soft' concerns about patients, these were reported to a named GP and reviewed to identify where formal reporting such as safeguarding concerns, may be required.
- The practice met with staff from residential or nursing homes every 6 months to discuss patients changing needs, identify where staff required skills updates and to improve collaborative working.
- Patients with hearing loss were provided with alternative appointment booking facilities for example, text and email communications.
- A dedicated carers champion was employed by the practice. They actively identified carers of older and vulnerable patients to ensure records reflected the caring role and the carer was provided with advice and support to help maintain their caring role.

In addition the provider should:

- Ensure stocks of medicines are accounted for to keep a more accurate record of what had been used and what needs to be ordered.

Professor Steve Field CBE FRCP FFPH FRCGP

Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

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

Are services well-led?

Good

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

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What people who use the service say

We spoke with nine patients visiting the practice and three members of the patient participation group during our inspection. We received 23 comment cards from patients registered at the practice and saw the results of the last patient participation group surveys. The practice also shared their initial findings from their current 'friends and family' survey. We also looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey and the Care Quality Commission's information management report about the practice.

The majority of comments made or written by patients were positive and praised the GPs and nurses who provided their treatment. For example, about receiving prompt referrals to specialists and consultants; about seeing a named GP at most visits and about being treated with kindness and consideration.

We heard and saw patients generally found access to the practice and appointments easy and how telephones were answered after a brief wait. However, some comments indicated it was not always easy to get through to the practice during the first hour of the practice opening. The most recent GP survey showed 95% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practice's online booking systems to get appointments.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was generally private enough for most discussions they needed to make. Patients told us how GPs supported them at times of bereavement and provided extra support to carers. A significant number of patients had been attending the practice for over 10 years and told us about how the practice had grown but that they were always treated well. The GP survey showed 91% of patients said the last GP they saw or spoke with was good at giving them enough time and treating them with care and concern.

Patients told us the practice was always kept clean and tidy and periodically it was refurbished. Improvements included the process for requesting repeat prescriptions. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with paper protective sheets. 92% of patients describe their overall experience of this practice as good. Initial results of the practices 'friends and family' survey showed 93% of patients felt they would be likely or extremely likely to recommend Blackbrook Surgery to a friend or family member.

Areas for improvement

Action the service SHOULD take to improve

The practice should;

- Ensure stocks of medicines are accounted for to keep a more accurate record of what had been used and what needs to be ordered.

Outstanding practice

- The practice kept a record of 'soft' concerns about patients, these were reported to a named GP and reviewed to identify where formal reporting such as safeguarding concerns, may be required.
- The practice met with staff from residential or nursing homes every 6 months to discuss patients changing needs, identify where staff required skills updates and to improve collaborative working.

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- Patients with hearing loss were provided with alternative appointment booking facilities for example, text and email communications.
- A dedicated carers champion was employed by the practice. They actively identified carers of older and vulnerable patients to ensure records reflected the caring role and the carer was provided with advice and support to help maintain their caring role.

Blackbrook Surgery

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, a practice manager and a practice nurse. All team members had been involved in previous CQC inspections across a range of service types, including GP practices and hospitals.

Background to Blackbrook Surgery

Blackbrook Surgery Lisieux Way, Taunton. Somerset. TA1 2LB is located in a residential area close to the town centre of Taunton.

The practice is part of the Taunton Deane area Federation of GP Practices and has approximately 10200 patients. The facilities provided by the practice include nine consulting rooms, five treatment rooms used by practice nurses and health care assistants. There is level access into the practice and to all patient accessible areas; toilets are accessible with facilities for patients with disabilities. Parking is available on site. There are a range of administrative and staff areas including a training area. The practice is a registered GP training location.

There are seven GP partners in the practice. Three of the GPs work full time and four work part-time. Each GP holds a patient list and has a 'buddy' GP with knowledge of their buddy GPs patients. Four GP's are female and three are male. A salaried GP also works in the practice. There was one male and one female registrar GP working in the practice. In addition there is a lead nurse, two practice nurses and three health care assistants. The practice also employs a team of reception and administrative staff who are supported by practice and a practice manager and lead office administrator.

The practice has a General Medical Services (GMS) contract to deliver health care services, the contract includes enhanced services such as extended opening hours. This contract acts as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

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

The CQC intelligent monitoring did not place the practice in a risk band. 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 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

Detailed findings

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

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We carried out an announced visit on 13 November 2014 but had to postpone our inspection due to a power failure. We returned to complete our inspection on 10 December 2014.

We talked with the majority of staff employed in the practice. This included six GPs and two GP registrars, the practice nurse, a health care assistant, the practice manager and their deputy and six administrative/reception staff. We spoke with three members of the patient participation group, nine patients visiting the practice during our inspection and we received comment cards from a further 23 patients.

Good

Are services safe?

Our findings

Safe track record

The practice used a range of information to identify risks and improve patient safety. For example, reported incidents, accident reports, national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, there had been a power supply failure during our initial inspection. The failure had been reported, recorded and an action plan had been produced. We saw the outcomes of the reported event, which had been discussed at the next 'clinicians' team meeting.

We reviewed safety records, incident reports and minutes of clinical meetings where these were discussed for the last year. The actions taken and the subsequent learning showed the practice had managed them consistently over time and so could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last two years and we were able to review these. Significant events were a standing item on the practice clinical continuous professional development (CPD) meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. Where relevant, significant events were also discussed at quarterly multidisciplinary meetings where safeguarding concerns were also reviewed. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. For example, where they were discussed in team meetings. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms from the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked six incidents and saw records were completed in a timely manner. We saw evidence of action taken as a result, for example, during a recruitment process it was noticed that incorrect information had been stated and was reported by a receptionist. The concern was followed up and the job offer was withdrawn. A subsequent review of the practice's recruitment policy was undertaken which ensured a clearer step-by-step process was followed.

Where patients had been affected by something that had gone wrong, in line with practice policy, they were given an apology and informed of the actions taken.

National patient safety alerts were disseminated by the senior partner, the GP trainer or the practice manager to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were discussed in clinical CPD meetings and staff meetings. This ensured all staff were aware of alerts that were relevant to the practice and when they needed to take action.

Reliable safety systems and processes including safeguarding

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

Contact details of the Somerset safeguarding teams were easily accessible in both written and computer based formats. Key contact telephone numbers were on staff notice boards in the reception/administration area of the practice.

The practice also kept a record of 'soft' concerns about patients. For example, if a patient was heard to shout excessively at their child whilst in the practice. These occurrences were reported to the designated safeguarding lead for the practice who reviewed the concerns and where patterns of behaviour or concern were identified an appointment was made to discuss the concerns with the patient. A formal alert could also be made to relevant organisations.

Good

Are services safe?

The practice had appointed dedicated GPs with lead responsibility for safeguarding vulnerable adults and children. They had been trained to level 3 in safeguarding children and also received training in vulnerable adults, and could demonstrate they had the necessary training which enabled them to fulfil this role. All staff we spoke with were aware who these lead staff were and who to speak with in the practice if they had a safeguarding concern.

There was a system which highlighted vulnerable patients on the practice's computer based record system. This included information to make staff aware of any relevant issues when patients attended appointments. For example, children subject to child protection plans or an older patient with a diagnosis of dementia. Similar arrangements were in place to identify where patients were supported by a carer. These records were linked so that if the carer had to go to hospital the patient would not be neglected through the loss of their carer.

There was a chaperone policy. Information about the availability of chaperones was visible on the waiting room noticeboards and in consulting rooms. All nursing staff, including health care assistants, had been trained to be a chaperone. If nursing staff were not available to act as a chaperone, the receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

The practice had a system for identifying children and young people with a high number of A&E attendances. Where a patient attended A&E three times the practice contacted the patient, made an appointment for them to discuss their problems and where necessary sent 'special notes' to the out of hour's service about the patient (special patient notes is a web based system that requires the clinician to enter data onto the out of hours service systems). A similar process was in place to follow up parents of children who persistently failed to attend appointments for example, for childhood immunisations.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy which ensured medicines were kept at the required temperatures, and which described the action to take in the event of a potential failure. We saw the practice staff followed the policy guidance and witnessed it in action during the first date of our inspection when a power failure required the removal of vaccinations to another practice.

Systems for stock control were less robust. Medicines were held securely but in several locations in the practice. Medicines required for the practice were ordered by one of the health care assistants. A record was not kept of how many of each item was in stock at a given time. This could result in a loss of medicines which the practice might be unaware of. New stock was ordered when it was seen to be running low or another member of staff highlighted the need for more of an item.

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 nurses and the health care assistant administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that nurses and the health care assistant had received appropriate training to administer vaccines.

An administrator had a lead responsibility for repeat prescribing. All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. Where medicines required a review the member of staff receiving the request brought these to the attention of the GP before further prescriptions were produced.

The practice had established a service for patients to pick up their dispensed prescriptions at other locations and had systems in place to monitor how these medicines were collected. They also had arrangements in place which ensured patients collecting medicines from these locations were given all the relevant information they required.

Cleanliness and infection control

Good

Are services safe?

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

The practice had a GP and practice nurse with lead responsibility for infection control. They had undertaken further training to enable them to provide advice on the practices infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had carried out audits for three previous years and that improvements identified were completed on time. Minutes of practice meetings showed that hygiene and infection control was discussed.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during minor surgery or during intimate patient examinations. There was also a policy for needle stick injury and information posters in consulting and treatment rooms about required actions staff should take.

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

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, weighing scales and the fridge thermometer and blood pressure monitors.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice had recognised that the office staff were slightly under resourced. They had recently interviewed two new apprentices to help improve resources and assist with practice support work. The practice staff we spoke with told us they tried to minimise the use of locum GPs to ensure continuity of patient care. The practice manager showed us records to demonstrate that actual staffing levels and skill mix were in line with planned staffing requirements.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. We saw that any risks were discussed at GP partners' meetings and within team meetings. For example, the practice manager had shared information about maintaining the security of the premises and clinical waste.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there

were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made to specialists for patients whose blood or urine samples showed unusual results. GPs gave examples of how they responded to patients who experienced a mental health crisis, including supporting them to access locally based emergency care and treatment and other support services.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (AED). An AED is a portable electronic device that automatically diagnoses life-threatening cardiac arrhythmias of ventricular fibrillation and ventricular tachycardia in a patient, and is able to treat them through defibrillation, the application of electrical therapy which stops the arrhythmia, allowing the heart to re-establish an effective rhythm. However there was no child sized emergency equipment such as airway tubes. When we spoke with the practice nurse about this they ordered equipment immediately. When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

Emergency medicines were available and staff told us they knew of their location. The area the emergency trolley was located was monitored by CCTV cameras, the trolley was covered and the medicines and equipment were in sealed boxes. However they were not completely secure. We raised concerns about the emergency trolley with the practice nurse. They arranged to have it relocated in a locked room adjacent to its previous location where some of the emergency medicines were already stored.

Emergency medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of acute pain. The reason for this was that when required they could be obtained from the pharmacy next to the practice. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this including dialling 999 to call an ambulance. The ambulance station was within a few hundred meters from the practice. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of a heating company to contact if the heating system failed. During our first visit to the practice there was a power failure. We saw how the practice implemented their plan and how they were able to continue to provide a service to those patients in most urgent need.

The practice had carried out a fire risk assessment that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills. Fire equipment including fire extinguishers and emergency lighting were routinely serviced and up to date, the last check had been carried out in September 2014.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence and from local commissioners. This information was accessed through the practice's intranet facility, journals and circulars as well as the online 'Somerset Navigator' service for clinicians. We saw minutes from clinical continuous professional development meeting meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure each patient received support to achieve the best health outcome for them.

We found from our discussions with the GPs and nurses and from the patient notes and referral letters sent to consultants that staff completed thorough assessments of patients' needs. These were in line with National Institute for Health and Care Excellence (NICE) guidelines, and were reviewed when appropriate.

The GPs told us they had lead responsibility for specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. We saw how they supported a newly appointed GP registrar with patient consultations and diagnoses by offering advice, a second opinion or just an opportunity to talk through their diagnosis process. We also heard how informal support was provided over coffee break and lunch time meetings. For example, GPs told us how they continually reviewed and discussed new best practice guidelines for a range of disorders. Our observations throughout the inspection confirmed that this happened. For example, we heard a discussion about housebound diabetic patients.

The senior GP partner showed us data from the local GP federation of the practice's performance for antibiotic prescribing, which was comparable to similar practices. The practice had also completed a review of case notes for patients receiving anti-coagulant treatment which showed all were receiving appropriate treatment and regular clinical review. We were shown the process the practice used to review patients recently discharged from hospital through reviewing discharge letters and summary information. The process required patients to be reviewed within two weeks by their GP according to the needs of the patient.

The practice used computer based tools and patient codes to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. The practice had completed care plans for 2.8% of its patients that were deemed to be at high risk of admission into hospital, each plan had the most up to date information in place.

Data from the practice showed that the practice was in line with referral rates to secondary and other community care services for all conditions. All GPs we spoke with used national standards for the referral of patients with dermatological problems. Patients were referred to a consultant within a week and were seen within 18 weeks. We saw minutes from meetings where regular reviews of elective and urgent referrals were made, and that improvements to practice were shared with all clinical staff.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in their decision-making.

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 practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us nine clinical audits that had been undertaken in the last two years. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, an audit of patients with chronic obstructive pulmonary disease (COPD) who had been admitted to hospital. An average of 28 patients had been admitted

annually over a three year period. The audit had identified the need to use the community COPD service more, patients to be advised to contact their GP sooner and to contact patients who did not attend reviews. We were told by the GPs we spoke with that numbers of hospital admissions had declined for these patients following the actions taken. Other examples included audits on cervical cytology, intrauterine devices and implants, enhanced anticoagulation service and urinalysis protocol.

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) or Somerset practices quality system (SPQS). QOF is a national performance measurement tool. For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. SPQS is a federation led initiative being piloted in the Somerset area covering locally centred performance data. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes.

The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. For example, 98% of patients with diabetes had a record of

estimated glomerular filtration rate (eGFR) or serum creatinine testing in the previous 15 months. The practice met all performance standards for QOF in diabetes/ asthma/ chronic obstructive pulmonary disease (lung disease). The QOF data for patients with diabetes indicated that recorded micro-albuminuria testing in the previous 15 months was lower than the federation average. The practice showed us data about how improvements in reviewing patients had resulted in these figures reducing. This practice was not an outlier for any QOF (or other national) clinical targets.

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

There was a protocol for repeat prescribing which was in line with national guidance. Staff regularly checked that patients receiving repeat prescriptions had been reviewed by the GP. They also checked that all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence which confirmed that after receiving an alert, the GP who had the patient on their list had reviewed the use of the medicine in question. Where they continued to prescribe it they outlined the reason why they decided this was necessary. The evidence we saw confirmed that the GPs, through holding personal patient lists, had oversight and a clear understanding of best treatment for each patient's needs. The GPs we spoke with told us the personal list system allowed for better continuity of patient care.

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. As a consequence of staff training and better understanding of the needs of patients, the practice had increased the number of patients on the register, including all vulnerable patients, to 2.8% of the patient list.

The practice also participated in local benchmarking run by the Taunton and Deane Federation. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area, for example, with childhood vaccinations.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records which we saw were incomplete, the practice manager told us updating the records was in progress. However when we spoke with staff they told us they had completed mandatory courses such as annual basic life support and infection control. We noted a good skill mix among the GPs with two having additional diplomas in sexual and reproductive medicine, two having additional diplomas in

family planning and two with diplomas in obstetrics and gynaecology. Other GPs had diplomas in other aspects of clinical care which enabled staff to seek specialist advice from within the practice.

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. Three of the GPs we spoke with had been successfully revalidated recently and showed us evidence of compliance with annual appraisal and continuous professional development requirements. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation had been confirmed by NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses for example, in family planning. The practice was a training practice with two GP registrars in post. GPs who were training to be qualified as GPs were offered extended appointments with their patients and had access to a senior GP throughout the day for support. We received positive feedback from the trainees we spoke with.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. Those with extended roles for example, who saw patients with long-term conditions such as asthma, **chronic obstructive pulmonary disease** (COPD), diabetes and coronary heart disease, had completed appropriate training.

Working with colleagues and other services

The practice worked with other service providers to meet patients' needs and manage complex diagnoses. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, information from the out-of-hours GP service and the 111 service, both electronically and by post. These documents were scanned onto the patients' computer based records. The practice had a protocol outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers. These were done on the day they were received. The GP who saw these documents and results was responsible for any required action. All staff we spoke with understood their roles and felt the system in place worked well.

The practice was commissioned for a new enhanced service which was to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that the protocol for actioning hospital communications relevant to discharge was working well in this respect. The practice undertook a minimum of annual audits of follow-up appointments to ensure inappropriate follow-ups had been clearly documented and that no follow-up appointments were missed.

The practice held multidisciplinary team meetings quarterly to discuss the needs of complex patients, for example, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. We were told by GPs that patients with emerging or pressing needs were discussed at monthly clinical meetings to ensure their needs were addressed promptly. Staff felt this system worked well and remarked on the usefulness of the forum as a means of sharing important information.

Information sharing

The practice used computer based systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. Electronic systems were also in place for making referrals, and the practice made the majority of referrals last year through the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. Patients who were the most vulnerable and most likely to be admitted into hospital were given care plans to keep at home. The care plan was signed by the patient, the carer (if applicable), the named

accountable GP and the care coordinator (where appropriate). Information about who had care plans was provided to the out of hour's service and ambulance teams. One GP showed us how straight forward this task was using the electronic patient record system and highlighted the importance of this communication with A&E. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 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 system to coordinate, document and manage patients' care. All staff were fully trained on the system, and commented positively about the system's safety and ease of use. This software enabled scanned paper communications, such as those from hospital, to be linked to specific patient notes and saved in the system for future reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke to understood the key parts of the legislation and were able to describe how they implemented it in their practice. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff, for example, with making do not attempt resuscitation orders. This policy highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. We saw how GPs involved independent mental capacity assessors (IMCAs) where patients ability to consent to treatment was in doubt. The decisions made were clearly recorded on the patient's records.

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 writing. These care plans were reviewed annually or more frequently if changes in clinical circumstances dictated it and had a section stating the patient's preferences for treatment and decisions. For example, all care plans had been reviewed in last year.

When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of Gillick competencies. (These help clinicians to identify children aged under 16 who have the legal capacity to consent to medical examination and treatment).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's written consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. Patients' verbal consent was similarly recorded.

Health promotion and prevention

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

It was practice policy to offer a health check with the health care assistant or a practice nurse to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering lifestyle advice to patients of all age groups and offering smoking cessation advice to smokers.

The practice offered text message appointment reminder notifications to patients, with the option for patients to cancel appointments through text messaging. Aortic aneurysm screening was provided in the practice and was available to patients from other practices. GPs signposted patients to health trainers and other local providers to promote healthier lifestyles for example, the leisure centre practice scheme. Information about these services was available in the reception area.

The practice also offered NHS Health Checks to all its patients aged 40-75. Practice data showed that about half of patients in this age group took up the offer of the health check, other patients were offered health checks

Good

Are services effective?

(for example, treatment is effective)

opportunistically at routine appointments. A GP showed us how patients were followed up within one week if they had risk factors for disease identified at the health check and how they scheduled further investigations.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability and all 52 patients were offered an annual physical health check. Practice records showed all had received a check up in the last 12 months. The practice had also identified the smoking status of most patients over the age of 16 and actively directed patients to services which could support them to stop smoking. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for cervical smear uptake was 90%, which was comparable to other practices in the CCG area. There was a policy to offer telephone reminders for patients who did not attend for cervical smears. The practice audited their records annually to identify patients who do not attend. There was a named member of staff responsible for following up patients who had not attended screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance for all immunisations was comparable with the CCG area. There was a clear policy for following up non-attenders by a named member of staff.

The practice kept a register of older patients who were identified as being at high risk of admission to hospital or who were nearing the end of their life. All had up to date care plans which were shared with other providers such as the out of hour's service. All patients over the age of 75 years had an allocated GP to ensure continuity of care and treatment. For older patients who lived in residential or nursing homes the practice met with the staff of the homes every 6 months to discuss patients changing needs, identify where staff required skills updates and to improve collaborative working.

A dedicated carers' champion was employed by the practice. They actively identified carers of older and vulnerable patients to ensure records reflected the caring role and the carer was provided with advice and support to help maintain their caring role. All older patients received structured annual medication reviews if they took multiple medicines. Treatment was adjusted as required following these reviews.

Patients with long term conditions had structured annual reviews for various conditions such as diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. Patients with a diagnosis of diabetes had routine access to clinics and other services such as blood testing and advice. The most vulnerable patients with long term conditions had a summary care record which was shared with other providers such as the out of hour's service.

We saw from the patient records there was clear documentation of health promotion and lifestyle advice in the patients' notes. We saw evidence that multidisciplinary case management meetings had taken place for the most vulnerable patients with long term conditions. All patients had a named GP through the practice having individual patient lists and a buddy GP system which facilitated continuity of care and treatment. We saw from patient records that the practice used text reminders to inform patients of review appointments. We were told the practice held three monthly palliative care reviews with hospice nurse and district nurses. This was confirmed by the meeting minutes we saw.

Families, children and young patients had access to a range of services within the practice and those provided in the health centre. These included ante natal services, baby clinics, family planning and sexual health clinics and speech therapy.

Immunisation rates for all standard child immunisations such as, infant meningococcal vaccinations and measles, mumps and rubella were in line with those in other local practices. We saw information was available for young patients visiting the practice about sexual health and the clinics and services available to them, for example, contraception advice. Families, children and young people from disadvantaged circumstances including families currently living in parenting observation and support units were supported by the practice. They were monitored during routine appointments and referrals made to relevant organisations such as safeguarding teams or children's services where concerns were observed.

Good

Are services effective?

(for example, treatment is effective)

Patients of working age had access to bookable appointments outside of working hours. Health checks were made available to them and reminders about these types of checks were made during routine appointments. Text message reminders were also used to ensure patients attended these appointments. Blood pressure checks were also made during routine appointments. Information was provided to these patients about lifestyle choices and clinics were available to them to help stop smoking. An aortic aneurysm screening service (a way of detecting a dangerous swelling (aneurysm) of the aorta – the main blood vessel that runs from the heart) was based in practice and promoted to this group of patients

Patients whose circumstances may make them vulnerable were identified on a register in the practice. The list included those patients from various vulnerable groups for example, patients with learning disabilities and children from outside the area living in family observation units. All patients with diagnosed learning disabilities received annual follow-up appointments and regular health checks. Children from outside the area living in family observation units were registered as temporary patients along with their parents so they could access a GP.

Those patients in the 2.8% most vulnerable group were reviewed by multidisciplinary teams which ensured the most effective care and treatment was provided and care plans were updated. These patients were also provided with information about local support groups and voluntary organisations such as those who provided community therapy services and speech and language therapy.

Patients were able to access the practice services without fear of stigmata or prejudice, and a translation service was available. The practice arranged for secretarial support for patients having difficulty using the 'Choose and Book' system or making secondary care appointments.

Patients who experienced poor mental health were provided with a range of services through referrals to locally based services, for example, Child & Adolescent Services (CAMHS) and Adult mental health services. We saw evidence that elderly patients with a diagnosis of dementia had advance care planning in place as well as access to speech and language therapists and psychological services. Carers of these patients were identified and referrals were made to a local carers organisation to enable them to receive support if they required it.

A named accountable GP was available to patients who experienced poor mental health with flexible appointment times including same day emergency appointments and telephone consultations. Staff were trained to be sensitive to patients' distress and to offer extended appointment times when appropriate. GPs were informed immediately of any undue distress being shown by patients.

The GPs told us the practice had good working relations with the local mental health Crisis Team and could book same day assessments for patients in need of prompt interventions. Records showed there were annual reviews for patients on the mental health register. The annual review included help and support for carers. The practice used review appointments to opportunistically encourage health promotion and had a system for identifying patient who did not attend appointments for depot anti-psychotic injections.

A self-referral 'talking therapies' counselling service was based in the practice which GPs and nurses signposted patients to. Information leaflets about this service were available in the waiting areas of the practice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey and a survey of 362 patients undertaken by the practice's patient participation group (PPG). The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 93% of respondents rated the practice 'above average' for patients, who rated the practice as good or very good. The practice was rated above average for its satisfaction scores on consultations with GPs and nurses, with 89% of respondents saying the GP was good at listening to them and 91% saying the GP gave them enough time.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 23 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Two comments were less positive, the common theme was about waiting times in the practice. We did not observe excessive waiting times during our inspection. We also spoke with nine patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located in a separate area to the reception desk and was shielded by glass partitions which helped keep patient information private. A separate window was available for patients requesting repeat prescriptions to prevent queues building up and reception desk conversations from being overheard. In response to patient and staff suggestions, a system had been introduced to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us he would investigate these and any learning identified would be shared with staff. There was a clearly visible notice in the patient reception area stating the practice's zero tolerance of abusive behaviour.

Patients whose circumstances may make them vulnerable or who experienced poor mental health were able to access the practice without fear of stigma or prejudice. We saw staff treated patients from these groups in a sensitive manner. Appointments were made at quieter times of the day or at weekends to avoid upsetting patients sensitive to noise. GPs were informed when the patient arrived so they were not kept waiting. Staff told us training had been made available to them about how to deal sympathetically with all groups of patients.

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 82% of practice respondents said the GP involved them in care decisions and 88% felt the GP was good at explaining treatment and results. Both these results were in-line with other practices in the CCG area. The results from the practice's own satisfaction survey showed that 94% of patients said they were sufficiently involved in making decisions about their care.

Patients we spoke to 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

Good

Are services caring?

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.

The GPs we spoke with about patient involvement were all able to provide examples of involving patients in decisions about care and treatment. For example, we heard about a patient who required treatment for a serious condition and wished to know more about the different options available and the risk of side effects. A second consultant opinion was arranged and once this had happened, the patient and GP met to consider the information available and enable the best choice to be made for that individual.

Staff told us that translation services were available for patients who did not have English as a first language through a telephone translation service. We saw notices in the reception areas informing patents about this service. We also saw notices in the reception and consulting areas in different languages informing patents that a chaperone service was available. The practices website also offered a translation service to help patients read information in their own language.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 94% of respondents to the Patient Participant Group survey said staff showed care and concern when the discussed sensitive issues. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. Patients told us GPs contacted them following bereavements or when experiencing difficult times in their lives to offer support. They also commented on the support provided by the carer champion.

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

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patients 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 Area Team and Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements and manage challenges to its population. The CCG priorities are,

- Encouraging communities and individuals to take more control of and responsibility for their own health and wellbeing
- Prioritising joined up person centred care
- Transform the effectiveness and efficiency of urgent and acute care across all services
- Sustain and continually improve the quality of all services

These priorities were reflected in the practices vision and in the way it delivered services to its patients. It engaged with its patients and worked towards improving the services offered. The practice had implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included, improving patient privacy in the waiting area, providing more online services including appointment booking and requesting prescriptions and providing better information to patients through a quarterly newsletter.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Patients with learning disabilities received routine medicines and health reviews. The practice met with residential and nursing home managers twice a year to review patient care, discuss staff training needs and to support staff development. Families from outside the area living in family observation units were provided with access to GP services. The working population was supported to remain in work through flexible and weekend appointments and through the provision of 'fit notes'. A 'fit note' allows GPs to advise that individuals "may be fit for work" taking into account the GPs advice, or that they are "not fit for work".

The practice had access to online and telephone translation services and had a hearing loop system to help patients wearing hearing aids to hear clearly in reception and waiting areas. Patients with hearing loss were provided with alternative appointment booking facilities for example, text and email communications.

The practice provided equality and diversity training through e-learning. Staff we spoke with about this type of training told us they had completed equality and diversity training and that equality and diversity was at the heart of their patient centred way of working.

The premises and services had been adapted to meet the needs of patients with disabilities. We saw that the waiting area was large enough to accommodate patients with wheelchairs and pushchairs and allowed for easy access to the treatment and consultation rooms. Accessible toilet facilities were available for all patients attending the practice including baby changing facilities. The practice was situated on the ground floor of the building with all services for patients at this level. There were turning areas in the corridors for patients with mobility scooters. This made movement around the practice easier and helped to maintain patients' independence.

The practice had a population of mainly English speaking patients though it could cater for other different languages through translation services. Where communication was difficult for other reasons the practice used other forms of communication. For example, patients with profound hearing problems, or speech difficulties which make it hard for them to express themselves clearly over the phone were offered a range of options for making face-to-face appointments, including email, fax, text and direct booking at the reception desk.

Access to the service

The practice used the recognised telephone triage system for all appointments. All patient requests for a GP appointment by phone or on-line resulted in a call back from a duty GP later that day. This system was in use for both urgent same-day appointments and for non-urgent book-ahead appointments. Patients stated they were

Good

Are services responsive to people's needs?

(for example, to feedback?)

generally happy with the system but there could be circumstances where patients could find this arrangement inconvenient and it might lead them to use other services such as accident and emergency. There was no protocol in reception describing how the triage system worked and what would be done in circumstances where a call-back later in the day would not be suitable.

Appointments were available from 8:30 am to 6:30 pm on weekdays. The practice offered a small number of appointments each week for patients who found it difficult getting to the practice during normal opening hours. These were available on one evening per week, usually a Monday or Wednesday and on a Saturday morning. The practice closed on Tuesday lunchtime between 1:00 pm and 2:00 pm for staff training but a GP remained on call during that time for emergency advice/care. Patients had access to urgent appointments each day with non-urgent appointments being bookable in advance.

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

Longer appointments were available for patients who needed them and those with long-term conditions. These included appointments with a named GP or nurse. Home visits were made to eight local care homes as required by two named GPs and to those patients who were housebound.

The practice had analysed the demand for nurse appointments and had recognised patients often had to wait for appointments. The practice was in the process of recruiting an additional nurse to reduce waiting times and to provide additional clinics.

Patients were generally satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to and they could see another GP if there was a wait to see the GP of their choice. In the last patient survey 78% of patients stated the appointments system was 'efficient' or 'very efficient'. Comments we received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, one patient we spoke with told us how they needed an urgent appointment, had contacted the practice in the morning and had been given an appointment later that morning.

There were no homeless patients currently registered with the practice. Two GPs were trained to provide treatment and support for patients with substance misuse problems but currently there were no patients requiring this support. One GP partner had a special interest in learning disabilities, they covered the healthcare support for the majority of learning disability patients registered with the practice. These patients received an annual health check as well as 6 monthly meetings with learning disability consultant to review those with more complex needs.

The practice provided in-house anticoagulation monitoring, a disease modifying anti-rheumatic drug therapy (DMARD) monitoring service was also available. DMARD medicines are used to ease the symptoms of rheumatoid arthritis and reduce the damaging effect of the disease on the joints. A 24-hour ambulatory electrocardiogram (ECG) was arranged in conjunction with a nearby practice for patients who needed their heart monitoring. Family planning services for long acting reversible contraceptives and intrauterine devices were also provided by the practice.

Listening and learning from concerns and complaints

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

We saw that information was available to help patients understand the complaints system. For example, posters were displayed in the waiting area and information was provided on the practices website about how to complain or make service improvement suggestions. However the information shared with us by the practice did not include informal or verbal complaints and comments and could result in improvement suggestions being lost. Most

Good

Are services responsive to people's needs?

(for example, to feedback?)

patients we spoke with were aware of the complaints process to follow if they wished to make a complaint. None of the patients we spoke with told us they had ever needed to make a complaint about the practice.

We looked at two complaints received since April 2014 and found these were satisfactorily handled and dealt with in a timely way. We saw from meeting minutes that the practice shared learning from complaints with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. The practice vision and values was to provide comprehensive modern primary care for patients, to provide a high standard of health care and to encourage self-help by health promotion, disease prevention activities and by active management of chronic disease, and to improve practice through audit and research. All the members of staff we spoke with told us they knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at nine of these policies and procedures. All policies and procedures we looked at had been reviewed annually and were up to date.

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

The practice had measured their performance by using Somerset practice quality scheme (SPQS) data and the Quality and Outcomes Framework (QOF). All the data for this practice showed it was performing similarly with or better than the average local standards. We saw practice data was regularly discussed at monthly meetings and action plans had been produced to maintain or improve outcomes.

The practice nurse told us about a local peer review system they took part in with neighbouring GP practices. The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, putting alerts on patient's records if the patient was diagnosed with diabetes and had vascular impairments which increased their risk of ulcers or possible limb amputations.

The practice had robust arrangements for identifying, recording and managing risks. The practice manager showed us the risk log, which addressed a wide range of potential issues, such as loss of utilities such as electricity of water. We saw that the risk log was regularly discussed at team meetings and updated in a timely way. Risk assessments had been carried out where risks were identified and action plans had been produced and implemented. For example, during a recent electricity supply failure.

Leadership, openness and transparency

The practice employed a flat management structure with all partners having an equal say in the management of the practice. We saw from minutes that team meetings were held regularly, at least monthly. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings. We also noted that team half day, away days were held twice a year.

The practice holds quarterly multidisciplinary safeguarding, end of life care and child protection meetings. They also have regular clinical meetings where they discuss complaints, significant event audits as well as relevant evidence-based updates such as changes to National Institute for Health and Care Excellence (NICE) guidelines. The GP registrars were encouraged to give presentations on the research projects they undertook. The partners encouraged a learning culture for all staff through an investment in online learning.

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

Are services well-led?

Good

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

The staff we spoke with told us there was an open culture within the partnership which allowed them to raise concerns or make suggestions for improvement. They told us there were informal social gatherings organised for all staff to help promote an open culture within the practice.

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. We reviewed the last patient participation group report from January 2014. The main themes were about privacy in the waiting area and online services. The practice manager showed us improvements that had been made to the waiting area which included, a separate area for requesting repeat prescriptions, a queuing system and music being played. Online appointment bookings and repeat prescription requests were available.

The practice had an active 'virtual' patient participation group (PPG) which had steadily increased in size but was not currently active. The PPG included representatives from various population groups; including those that worked, older patients and those in vulnerable circumstances. The PPG had carried out an annual survey and met annually. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We met with representatives of the PPG who told us the practice had engaged with them and acted on their feedback.

The practice had gathered feedback from staff through staff meetings, appraisals and informal discussions. Staff told us they felt able 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.

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

Management lead through learning and improvement

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

The practice was a GP training practice with two GP registrars in post at the time of our inspection. The registrars had experience in hospital medicine and were spending a period with the practice to gain experience in family medicine. The registrar told us they were supported by two supervising GPs in the practice and could always access other GPs for advice or opinion. They told us about the useful practice intranet system and the information it provided as well as other resources available to them for example, journals and health publications. They commented positively about the support they received and the way the practice was managed.

The practice had completed reviews of significant events and other incidents and shared the learning points with staff at meetings. This ensured the practice staff were informed and helped the practice provide improved outcomes for patients.