North Curry Health Centre

Quality Report

Greenway, North Curry,
Taunton, Somerset, TA3 6NQ
Tel: 01823 490505
Website: www.northcurryhealthcentre.co.uk

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at North Curry Health Centre on 2 June 2015. Overall the practice is rated as good.

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

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

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

We saw some outstanding practice:

Summary of findings

- The provider had good systems in place to monitor, manage and audit anticoagulation and identification of atrial fibrillation (abnormal heart rhythm) which enhanced patient care and showed that the practice achieved standards above best practice guidelines.
- The practice had increased provision of palliative care for the practice population including opportunities for admission to the local hospice and access to out of hours emergency care by raising in excess of £28,700 for the local hospice.
- The practice had regular and innovative training for clinical staff on dealing with emergencies in primary care. We saw that this focused training had resulted in successful outcomes for patients with a medical emergency.

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

Importantly the provider should:

- Consider how it could maintain one database system for all staff training.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

Summary of findings

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

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice, in association with Age UK hosted gentle exercise classes one afternoon each week.

People with long term conditions

Good

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

The practice had guidelines for all major chronic long term conditions in line with national guidance and used these in combination with templates to guide chronic disease management.

Families, children and young people

Good

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

The practice had a dedicated noticeboard with information and resources for young patients.

Working age people (including those recently retired and students)

Good

Summary of findings

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability. It offered longer appointments for people with a learning disability.

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

The practice used the County Council and NHS integrated independent living service ('Enablement' service) to make referrals when they could recognise patients were in need of additional support to maintain their independence.

People experiencing poor mental health (including people with dementia)

Good

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

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. Staff had received training on how to care for people with mental health needs and training was planned for staff to consider the needs of patients living with dementia.

The mini mental state examination (MMSE) devised by the Alzheimer's Society or the Test Your Memory (TYM) test (Royal College of Psychiatrists) was used to assess patients where there were concerns they were possibly developing dementia.

Summary of findings

What people who use the service say

We received 46 completed Care Quality Commission comments cards where patients expressed their views of the service. Almost all of the comments were positive with patients describing a good atmosphere, calm surrounding and an excellent service. Patients told us they were treated with dignity and respect, kindness and care by friendly and helpful, yet professional staff.

The receptionists, dispensing staff were mentioned by many patients and people told us about their experiences of consultation with their GP. Patients told us their consultation was very thorough, the GP listened and gave them the time they needed. One patient told us they always felt satisfied when they left the practice and another mentioned the supervision they received from their GP during an illness. Patients mentioned the dispensing facility with one person describing it as a "godsend" for the rural community.

Two patients mentioned difficulty in getting appointments although others said they were always able to have an appointment that suited them.

One patient told us that they received good consistent care for his wife. This included telephoning for emergency care out of hours as the doctor that had attended on behalf of the ambulance service was one of the partners who knew their medical history.

We spoke to two members of the Patient Participation Group (PPG). The practice had an active PPG with 3 members and 4 virtual members of varied ages and included representation from patients with long term conditions and those from the rural farming community. They told us the GP's actively engaged and supported the group and the staff were aware of the different needs of the practice population. They told us that the practice provided good continuity of care when dealing with emergencies as one GP worked with the SAVES Somerset scheme; end of life care and carers. We were told of examples that illustrated this feedback.

Areas for improvement

Action the service SHOULD take to improve

Consider how it could maintain one database system for all staff training.

Outstanding practice

- The provider had good systems in place to monitor, manage and audit anticoagulation and identification of atrial fibrillation (abnormal heart rhythm) which enhanced patient care and showed that the practice achieved standards above best practice guidelines.
- The practice had increased provision of palliative care for the practice population including opportunities for admission to the local hospice and access to out of hour's emergency care by raising in excess of £28,700 for the local hospice.
- The practice had regular and innovative training for clinical staff on dealing with emergencies in primary care. We saw that this focused training had resulted in successful outcomes for patients with a medical emergency.

North Curry Health Centre

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 advisor.

Background to North Curry Health Centre

North Curry Health Centre is a rural practice providing services to over 3,900 patients in an area of approximately 40 square miles from Curland to Burrowbridge and Fivehead to Henlade.

It is located at Greenway, North Curry, Taunton, Somerset TA3 6NQ. The practice is a medicines dispensing practice and almost all patients take advantage of this facility. The practice is part of the Taunton Deane GP Federation.

The partnership comprises two male GPs who employ two further GPs, both female. The practice supports a female GP registrar. Between them the GPs provide 23 sessions each week. The practice employs a manager, three nurses, a health care assistant, five dispensary staff and four administrators along with, a medical secretary.

The premises were purpose built in 1981 and include five consulting rooms and two treatment rooms.

The practice patient population is weighted towards older patients with some commuters, locally employed patients and those whose work involves farming. Patients are from a wide range of social background. There is high employment levels and low deprivation in the area.

The practice is open from 8.00 am until 6.30 pm each weekday. The dispensary is open from 9.00 am until 6.30 pm each weekday. Appointments are available from 9.00 am until 11.45 am and from 4.40 pm until 6.10 pm each day.

In addition to a general medical services contract (GMS) the practice held contracts for enhanced services. An enhanced service is above what is expected from the GMS contact. These included contracts for avoiding unplanned hospital admissions, responding to minor injuries and immediate care and first response services along with a range of enhanced service contracts for immunisation and monitoring.

The practice contracts it's Out Of Hours service to Somerset Doctors Urgent Care and patients can gain assistance by telephoning the NHS 111 telephone number.

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 requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

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

Detailed findings

- 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 that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 June 2015.

During our visit we spoke with a range of staff including the GP partners, salaried GP and a GP trainee. We also spoke with nurses, reception staff, the medical secretary and dispensing staff in addition to the practice manager.

We reviewed 46 Care Quality Commission comment cards where patients and members of the public shared their views and experiences of the service.

We looked at a range of policies, procedures and records relating to the running of the practice.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients.

The dispensary manager was identified as the lead member of staff for receiving alerts and guidance from the Medicines and Health Related Products Agency such as the most recent in respect of the use of ventilators. They disseminated information to relevant staff. Alerts from the National Patient Safety Agency and National Institute for Health and Care Excellence were received into the practice and disseminated in the same way. We saw that the practice scheduled learning sessions around these alerts quarterly.

The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, in relation to an incident affecting catheterisation of a patient in the community and a delayed dermatology referral. The practice had received two complaints in the last year. We saw that the complaints had been managed appropriately, lessons learnt; practice changed as a result and where necessary an apology had been given. We saw that in one complaint the practice had gone beyond expectations for managing the compliant and provided the person with additional information to assist them further.

We reviewed safety records, incident reports and minutes of meetings where significant events and complaints were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the longer term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of 16 significant events that had occurred during the last year and saw this system was followed appropriately. There were dedicated meetings to discuss significant events and alerts. In 2014 the practice recorded 13 significant events and three so far in 2015.

There was evidence that the practice had learned from these and that the findings were shared

with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

We reviewed documentation in respect of significant events and saw variable quality in the recording. For example, whilst there was comprehensive documentation including actions and follow up for three we looked at, for another it was not as well documented. This related to a successful resuscitation of a patient. Although the practice staff had been involved in a debrief session which included analysis and lessons learnt, the practice had not fully documented the incident as a significant event.

We discussed an event where there was delay in a patient receiving medical intervention due to another health care organisation. We saw that the practice had undertaken an investigation and included the member of staff and senior representative from the other organisation. We saw that the other organisation changed its policy as a result of the investigation.

Following one significant event when a GPs dictation tape was mislaid, the practice undertook a significant event analysis which resulted in the introduction of a thorough dictation tracking system. Any dictation tapes could be tracked in the practice which prevented any reoccurrences of this nature. We saw that this process worked well.

Significant events were discussed with clinical, admin and reception staff at the monthly staff training events and all staff at the quarterly practice meetings. If applicable they were also discussed with district nurses and dispensary staff. If training or improvement was required after a significant event had been analysed, a follow up review date was recorded in order to monitor that the required actions had been undertaken.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to

recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible.

The practice safeguarding policy was based on locally agreed procedures. One of the partner GPs was the lead for child protection and safeguarding vulnerable adults and were the first point of call within the practice for advice. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

The lead told us they liaised with the practice manager to ensure all staff had checks with the Disclosure and Barring Service (DBS). 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 held three monthly safeguarding meetings involving all staff. All children and vulnerable adults on the 'at risk' register were discussed. We were told the health visitor was always invited to the meeting but often was unable to attend. All those patients identified as being at risk were identified on the electronic patient record system so staff were alerted to this.

The practice used an external training provider for child protection and safeguarding vulnerable adults training. The last child protection training was in April 2014 when the Clinical Commissioning Group (CCG) safeguarding lead attended the practice to deliver child protection training at level three for GPs and level two training for other staff. The CCG lead delivered safeguarding vulnerable adults training to all staff in April 2015.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

We discussed various patients on the register and found the practice acted appropriately and the cases were well managed. These included cases that involved neglect, potential financial abuse of an older patient and a child who received support from an external agency.

The practice chaperone policy was displayed. A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure. One of the GPs told us a chaperone was offered for all intimate examinations and only nurses were used as chaperones. They said in the event of the GP being needed elsewhere for an emergency the chaperone would remain with the patient for their safety. Another GP told us they always documented when a chaperone was offered, accepted or declined in patient records. One nurse told us that they had used reception staff to look after children during intimate examinations. This was against practice policy. We raised our concerns that reception staff were being used without chaperone training or Disclosure and Barring checks. The practice management were unaware and took immediate action to rectify this. We were satisfied that the practice had taken appropriate steps to rectify our concern.

Medicines management

There were systems in place for the safety of dispensary staff and medicines. Controlled medicines that required additional secure storage were kept secure and standard operating procedures were in place that set out how they were managed.

Stocks of medicines were scanned into the computer system to monitor quality and quantity. Staff were alerted to any changes in brand of medicines. For controlled medicines there was an additional physical check.

The practice participated in the dispensing services quality scheme (DSQS). This involved an annual audit to ensure safe systems were in place. The dispensary manager audited controlled medicines monthly. One of the GPs was the dispensing 'lead' and monitored dispensing to ensure DSQS was being adhered to. We saw that this included annual audits. They told us during the last check they found that not all standard operating procedures were being followed all of the time by all staff. However all 'key' standards of DSQS were met. The dispensing lead had introduced a thorough quarterly checking process for all medicines and reminder systems to carry out the checks.

Good

Are services safe?

The practice had support from the Clinical Commissioning Group medicines management team. The dispensary manager told us they found the support useful as they conducted audits and assisted with medicines changes.

Medicines that required refrigerated storage were kept in designated fridges. The temperature of the fridges was checked daily and staff were prompted to check them. The fridges had alarms and a temperature monitoring device that allowed staff to monitor temperatures out of hours. The fridge temperature monitoring policy referred to temperature monitoring however, did not outline what action staff should take if there were found to be problems with the fridges.

Nurses kept a chart to record stock balances of medicines held in the treatment room.

Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

Any alerts received in respect of medicines or medical devices were checked by the dispensary manager and GP lead for the dispensing service. They told us how they had responded to alerts in respect of various medicines. For example, following an alert about an anti-diabetic medicine there were plans to review and where needed change medicines for some patients who may be affected.

When GPs prescribed medicines the prescription was received into the dispensary and the GP was alerted so they could sign the prescription before the medicines were dispensed.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again. Following a significant event when a patient was given the wrong prescription the dispensary had introduced extra checks to ensure repeat medicines were dispensed for the correct patient.

The dispensary manager carried out three monthly checks of the medicines the GPs carried with them on home visits. We checked the medicines for emergency treatment carried in one GPs bag. They were all within their use by date. Nurses kept a chart to record stock balances of medicines held in the treatment room. We saw that there was a good organised system for storing medicines within the treatment room.

There were standard operating procedures (SOP) for repeat prescribing and dispensing on the shared drive of the practice computer system. Each member of staff had their own folders within the computer system held at the practice for SOPs.

Dispensary staff responded to electronic requests for repeat prescriptions. These staff had access to training modules through a learning academy and we were told these covered subjects such as endorsing medicines, drug tariff and moral dilemmas. Training was also available through the medicines buying group for subjects including controlled medicines management, standing operating procedures (SOP) and use of inhalers.

Patient's medicines were reviewed every six months. We discussed the potential conflict between prescribing and dispensing with the dispensing lead. They told us the practice only prescribed medicines included in the Clinical Commissioning Group's (CCG) formulary (list of medicines).

Dispensing staff monitored older patient's compliance with the directions provided by their GP in relation to the taking of medicines. Where older patients found difficulty the practice could issue prescription in monitored dosage blister packs.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to in a PGD.

Cleanliness and infection control

The policy for cleanliness and infection control was in place, however it did not mention the need for infection control audits as outlined in the NHS National Patient Safety Agency specifications for cleanliness in the NHS (Guidance on setting and measuring performance outcomes in primary medical care and dental practices -August 2010). There was no infection control audit of the practice although there was an annual audit of the arrangements for the building as a whole which included infection control.

Good

Are services safe?

The practice employed two cleaners who were part of the staff team. The cleanliness of the practice was audited and monitored by the practice manager. We observed the premises to be clean and tidy. We saw there were cleaning schedules in place.

Members of the Patient Participation Group told us the public areas of the practice were always clean and had no concerns around cleanliness or infection control. The said that on one occasion when a patient with muddy boots went into the practice and left a trail of mud, reception staff immediately cleaned up after them.

The practice received bulletins from the Clinical Commissioning Group (CCG) infection control nurse.

We looked at the infection control arrangements and saw nurses had a checklist for checking treatment rooms. There were paper privacy blankets and disposable curtains which were changed every six months. We saw supplies of liquid soap and paper hand towels close to washbasins in treatment rooms and washrooms. The practice used single use equipment where possible and we noted equipment such as spirometer and nebuliser was cleaned when used. There were policies and protocols for dealing with spillage of bodily fluids and sharps injury. Staff had appropriate immunisation.

We saw the practice had obtained health and safety information related to the prevention of legionella. The practice manager had conducted a risk assessment that included control measures, including monthly checks. We also noted an order had been placed for water sampling by an external specialist company.

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, spirometers, blood pressure measuring devices and the fridge thermometer.

One of the nurses checked equipment in the GPs consulting room each week to ensure that equipment, for example, needles for injection were within their use by date.

We saw the boiler was serviced regularly.

Staffing and recruitment

We looked at staff recruitment files. They showed staff applied by submitting a curriculum vitae (CV). They were issued a contract of employment and job specification after recruitment checks including obtaining two references, photographic proof of identity; another form of identification and where necessary a check with the Disclosure and Barring Service. These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

Staff signed a confidentiality agreement and we saw evidence of an induction programme. New staff were subject to probationary review after three and six months in post.

One of the partners had time away from work and locum GPs were used. When locum GPs worked in the practice, they were obtained though 'Somerset GP Locums Ltd', a dedicated locum GP agency, who carried out all relevant checks. Locum GPs were engaged to complete clinical duties and the other GP partner dealt with administrative tasks. There was a specific pack of information for locum GPs that was under review at the time of our visit.

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.

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. Each month the practice manager walked around the premises for the purpose of conducting a health and safety audit. Two staff had been identified to attend health and safety training.

Fire drills were conducted annually and if a new member of staff was employed. The fire brigade were called and staff were given the experience of using fire extinguishers. Fire safety risk assessments had been completed and reviewed in May 2015.

The GP partners told us in 2012 the practice was the winner in the regional Cardiac and Stroke Network 'Strike out Stroke' project that considered the quality of monitoring and anti-coagulation in patients with atrial fibrillation (abnormal heart rhythm). The practice provided one-stop, near patient testing, for patients on blood thinning medicines. We saw that the practice had remained the top practice in the area for identification of patients requiring anticoagulation. The practice had continued to carry out audits in relation to anticoagulation and atrial fibrillation. These audits demonstrated that the practice followed NICE guidelines and ensured patients received the most up to date medicines.

Arrangements were in place for patients with chronic obstructive pulmonary disease to be provided with medicines in case they needed them. Patients with asthma were provided with personalised action plans and spirometry was provided for diagnosis and monitoring.

The practice was similar to other practices and had low prevalence of patients diagnosed with diabetes so it instigated proactive screening for diabetes for patients at high risk. Patients with chronic diseases were screened for diabetes at the clinics they attended.

The practice used the County Council and NHS integrated independent living (enablement) service to make referrals when they could recognise patients required support in order to maintain their independence. The team included a social worker, occupational therapist and physiotherapist and when needed specialist mental health support could be arranged through the service.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. There were protocols for staff to follow in the event of an emergency on the practice computer system.

One of the nurses outlined the roles and responsibilities of staff in relation to a patient being taken ill, unconscious, having a cardiac arrest or acute asthma attack. In the event of emergency staff would summon help and others would make their way to support them. The member of staff closest to the emergency medicines and equipment would collect them from where they were stored.

All GPs were consistent in their response to our question about responding to medical emergencies. One GP provided local pre-hospitalisation emergency care through SAVES (Somerset Immediate Care Scheme) and was chairman of the British Association for immediate care. We spoke to a patient who told us that they often needed emergency assistance for their wife. They felt that it was helpful having a GP attend through the ambulance service that new his wife's medical history. We saw that the GP who took on this additional role was able to ensure continuity of care for the practice population.

One of the GPs taught staff basic life support skills annually. Clinical staff including trainee doctors received additional in-house training. The GP described a patient's symptoms and clinical staff had to decide what to do and what medicines to administer. We were told about a successful resuscitation of a patient in the practice. Staff told us that the focused scenarios had ensured they were up to date when dealing with emergency situations. We saw that staff at the practice had the knowledge and experience to deal with life threatening medical emergencies.

We checked the emergency medicines and found they were all in date and checked regularly. There was guidance with the medicines for responding to children and adults in an emergency provided by the Resuscitation Council UK.

We looked at the business continuity plan and saw it contained information regarding responsibilities of the practice manager, GP partners and staff. Copies of the plan were held off of the premises for use in an emergency by the practice manager and partners. The plan contained information relating to loss of premises, essential services, information technology systems (IT) and telephone system. The plan is supplemented by an inventory of IT equipment, emergency contacts list and clinical supplier contact list. In 2014 the area was subjected to a lengthy, major flood. Staff were able to tell us how they dealt with the incident. We

Good

Are services safe?

saw that learning had taken place and the practice was in the process of working with another practice to ensure a joint working policy was in place for future floods so that patients continued to receive good care.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, 176 patients with diabetes (91%) were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs held patient lists so patients had a named GP to monitor their care and treatment.

We saw the practice adopted templates for management of atrial fibrillation (abnormal heart rhythm) and diabetes screening which were clear, comprehensive and in line with good practice guidelines.

The practice had developed a communication tool for use between GPs and reception staff. It clearly identified when a patient needed tests or further appointments. The GP would identify what the patient needed and give it to the patient to hand to the receptionist. This ensured the correct type of test or appointment was arranged for the patient.

Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were cared for and treated based on need and the practice took account of patient's age, gender, race and culture as appropriate.

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated to support the practice to carry out clinical audits.

The practice had a system in place for completing clinical audit cycles. The practice showed us clinical audits that had been undertaken in the last 18 months. One of these was a completed audit where the practice was able to demonstrate the changes resulting since the initial audit. The audit related to screening and follow up of patients with impaired sugar control. It showed the practice had identified actions to be taken to ensure patients at risk of diabetes would be sent a letter inviting them for checks on their weight and blood pressure along with a blood test.

Another example involved an audit to confirm that the practice treatment of patients with atrial fibrillation (irregular heart rhythm) and receiving anticoagulation therapy was in line National Institute for Health and Care Excellence guidance, updated in July 2014. The audit identified proposals for change, interventions made, a

Good

Are services effective?

(for example, treatment is effective)

re-audit and conclusions. The audit showed improvement in documentation of risk and justification for prescribing decisions. It concluded the practice was meeting the National Institute for Health and Care Excellence standards.

The practice had opted out of the NHS Quality and Outcomes Framework (QOF) and was signed up to the Somerset Practice Quality Scheme (SPQS). This was a new scheme developed jointly between Somerset Clinical Commissioning Group, Somerset Local Medical Committee, local GP practices and NHS England aiming to improve primary care services for patients across Somerset.

The practice had guidelines for all major chronic long term conditions in line with national guidance and used these in combination with templates to guide chronic disease management.

The practice had a comprehensive system of recalling patients for checks. Each month there was a search on the electronic records system and patients were sent a letter if they were due to have a review of their care and treatment. For example a patient who had poor attendance for appointments in connection with their condition had telephone calls from their named GP.

The practice nurses ran clinics for patients with diabetes, asthma, chronic obstructive pulmonary disease and heart disease. The medication review system provided reminders for patients to attend for a review.

Performance for diabetes related indicators was similar to the national average except for the percentage of patients with diabetes having had immunisation against influenza which was lower than the national average. The percentage of patients with hypertension having regular blood pressure tests was also similar to the national average. The practice's prescribing rates were also similar to national figures.

There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The practice provided information to show 100% of patients with co-morbidities (the presence of one or more disorders or diseases) receiving multiple medicines had a medicines review within the last year. The information showed 91% of patients with diabetes had been seen during the last year and 83% had received a foot risk assessment. The practice had a proactive screening process for patients at risk of diabetes for example, patients with hypertension and a body mass index of more than 30.

Care plans were completed for patients over the age of 75 years. Where it was the patients wish to not be resuscitated, do not attempt cardiopulmonary resuscitation orders were completed. These are a legal document recording a person's wishes. When these were completed a paper copy was left at the patient's home and a copy was shared with the ambulance service and the Out Of Hours service.

The electronic record system alerted staff if a patient was also a carer, whether they were considered to be vulnerable, were a victim of domestic abuse or had a do not attempt Cardio-pulmonary resuscitation (DNARCPR) in place.

There was a discrete notice board in the office where staff maintained a list of vulnerable patients who were in hospital and those receiving end of life care. There was also a list of patients in the nursing home and residential care home.

The practice managed the care of 38% of patients at end of life in their own home. We were told how on one occasion a GP remained with a patient at the end stages of life. Average life expectancy for male patients was 79 years and 83 years for females. Palliative care meetings were held every three months and there were meetings to discuss vulnerable children and adults at the same frequency.

We discussed the care of a patient receiving end of life care with one of the GP partners. It highlighted that all key agencies were involved in the patient's care and treatment.

The practice had an avoiding unplanned admission policy. It described a clear protocol, applicable and relevant to the practice. The practice used a template for recording care plans for those considered to be at risk of emergency admission to hospital.

The partner GPs told us the practice had a proactive system for encouraging influenza vaccinations for older patients. This was reflected in the number of patients over the age of 65 years who had received seasonal influenza vaccination was 91% compared to the national average of 73%.

Good

Are services effective?

(for example, treatment is effective)

Following a significant event when a dictation tape was mislaid and led to a delay in referral the medical secretary had devised a management system so there was now dictation tracking. They now recorded when each letter had been typed and been given to the GP.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with three having additional diplomas in sexual and reproductive medicine; one with a diploma in obstetrics and a fellowship in immediate medical care and one with a diploma in practical dermatology. One GP had received a MBE for services to healthcare, particularly emergency medical care. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England). GPs provided weekly clinical supervision to nursing staff.

Each month the practice closed on Thursday afternoon for staff training during which significant events were looked at by the GPs and nurses. We saw the topics covered in past meetings which included domestic violence awareness, team building exercises, child protection training, health and safety and basic life support training. The practice was not able to provide an overview of the training staff had completed.

Staff appraisals were introduced in February 2015. There was an initial training session for staff in respect of the process and we were told almost all were complete for this year and those outstanding were for the nurses.

We saw that staff records had details of mandatory training and staff were able to tell us about the required training they had completed. However the practice should consider one system that records required training and completion dates.

Working with colleagues and other services

As part of the Taunton Deane Federation the practice worked jointly with other GP practices in this area of Somerset to commission health services.

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. Out Of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received.

Discharge summaries and letters from outpatients were usually seen and actioned when they were received. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 7.5% compared to the national average of 14%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract).

The practice held multidisciplinary team meetings every three months to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, 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. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

When parts of the practice catchment area were flooded last year, the practice worked with the ambulance service to provide medical cover in an emergency.

The practice provided primary medical services to a nursing home and a residential care home.

Good

Are services effective?

(for example, treatment is effective)

One of the GPs spoke about relationships with secondary care services in the area. They told us the services responded quickly to emails and telephone calls for advice. They said they had a dedicated telephone number so they had rapid access to consultants when advice was needed.

When there was an accident on the M5 motorway in 2011, involving a multiple vehicle collision involving cars and articulated lorries one of the GP partners responded by attending the scene and provided assistance to those injured working alongside emergency services.

Information sharing

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. We saw evidence there was a system for sharing appropriate information for patients with complex needs with the ambulance and out-of-hours services.

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record 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 to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. The GPs had attended training related to Mental Capacity including workshops provided by the community mental health team, Somerset GP Education Trust and the Devon Pentagon Group (for sessional GPs). Staff training in respect of safeguarding adults included mental capacity and best interest decision making.

Staff demonstrated awareness of Gillick competency principles. These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions. Staff said they would talk young patients through a procedure prior to obtaining consent so they were making an informed choice. Written consent was obtained and the consent form was scanned into the patient's record..

If a member of staff had concerns about a patient's ability to give informed consent they would speak with a GP.

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

Health promotion and prevention

The practice used information about the needs of the practice population to help focus health promotion activity.

All newly registered patients were asked to complete a health questionnaire and medical treatment was available from the date of registration. If a person is ill while away from home and are not registered with a GP where they are staying they can receive emergency treatment at the practice for up to 14 days. After that time they need to register a temporary or permanent patient.

All of the GPs provided contraceptive services including emergency contraception. One of the salaried GPs provided contraceptive implants and the practice had a recall system for all patients with intra-uterine devices and implants.

A midwife held anti-natal clinics in the practice every two weeks. The practice provided six week post-natal checks with the health visitor. The GP partners told us the practice breast feeding initiation rate was 91% compared to the Clinical Commissioning Group (CCG) average of 83%.

Good

Are services effective?

(for example, treatment is effective)

Two nurses held child immunisation clinics twice each month. If these were inconvenient appointments were offered at alternative times. Child immunisation rates were high with 100% vaccinations achieved in children under 12 months and almost 100% in those children under 24 months. All children registered with the practice had the meningitis C booster at the age of five years.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, influenza vaccination rates for the over 65s were 91%, and at risk groups 51%. The percentage of those over 65 was higher that the nation average of 73% and the at risk groups was similar to the national average.

Childhood immunisation rates for the vaccinations given to under twos ranged from 91 % for the Dtap/IPV booster (for diphtheria, tetanus, polio, whooping cough and haemophilus influenza type b (Hib)) to 100% for all others and five year olds from 83% to 100%. These were above national averages.

All patients over the age of 75 years had one of the partners as their named GP to provide a clear line of accountability and enable continuity of care. The practice perceived that older patients were more likely to request a morning appointment so the morning surgery appointments were extended to 15 minutes and double appointments could be booked if required.

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 giving smoking cessation advice to smokers. Information provided by the practice showed 84% of the 435 patients recorded as smokers, when they were last asked, had been given advice. The practice did not provide a formal smoking cessation clinic however, offered referral to a locally commissioned service.

The mini mental state examination (MMSE) devised by the Alzheimer's Society or the Test Your Memory (TYM) test (Royal College of Psychiatrists) was used to assess patients where there were concerns regarding possibly developing dementia. The GPs could refer patients to the service provided by Somerset Partnership for assessment and support including the psychogeriatric team.

The practice could also access support services from the Somerset Partnership mental health crisis team and had arranged for a counsellor to work in the practice on a voluntary basis.

There were chlamydia testing kits available for young people to take away with them.

The practice's performance for the cervical screening programme was just under 77%, which was below the national average of almost 82%. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

There were a variety of information leaflets available for patients to take away. Members of the Patient Participation Group (PPG) told us there were new leaflets added regularly. These included leaflets related to common conditions and medicines for self-care. Health promotional material was also displayed on the waiting room television monitor. We saw there was a notice board dedicated to sexual health and separate notice boards for children and carers.

There was equipment for patients to check their blood pressure in the waiting area.

The practice, in association with Age UK hosted gentle exercise classes one lunchtime each week.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey January – March 2014 and July – September 2014, a survey of patients undertaken by the practice's patient participation group (PPG) and patient satisfaction questionnaires sent out to patients by each one of the practice's partners and a salaried GP. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was also highly for its satisfaction scores on consultations with doctors and nurses. For example: Of those who completed the survey 90% said the GP was good at listening to them compared to the CCG national average of 85%. Similarly 89% said the GP gave them enough time compared to the national average of 85%. Of those who completed the survey 90% said the last nurse they said or spoke with was good at listening to them and 95%

Had confidence and trust in the last nurse they saw or spoke with. These were both above the national average of 78% and 85%.

We received 46 completed Care Quality Commission comments cards where patients expressed their views of the service. Almost all of the comments were positive with patients describing a good atmosphere, calm surrounding and an excellent service. Patients told us they were treated with dignity and respect, kindness and care by friendly and helpful, yet professional staff. The receptionists, dispensing staff were mentioned by many patients and people told us about their experiences of consultation with their GP. Patients told us their consultation was very thorough, the GP listened and gave them the time they needed. One patient told us they always felt satisfied when they left the practice and another mentioned the supervision they received from their GP during an illness. Patients mentioned the dispensing facility with one patient describing it as a welcome and necessary service for the rural community.

Two patients mentioned difficulty in getting appointments although others said they were always able to have an appointment that suited them.

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 / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

There were no arrangements to protect patient's privacy when having discussions with reception staff and we observed there to be a lack of confidentiality because patients waiting at the dispensary could overhear conversations. There was no signage asking patients to respect confidentiality by standing clear of the reception desk. We spoke to the practice and they advised us that reception staff were able to offer patients the opportunity to speak to them in private. The practice agreed to ensure patient were aware of this through signage.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

The practice raised funds for the local hospice and to date this amounted to 28 thousand pounds. We saw a letter from the hospice community fundraiser thanking the practice for its support. We saw that the funds raised had contributed towards the 'hospice without walls' initiative where local people were able to choose when and where they received support from the hospice.

At Christmas the practice held an open evening attended by the GP partners and practice manager with mince pies and mulled wine. They used the opportunity to promote membership of the Patient Participation Group.

Care planning and involvement in decisions about care and treatment

Good

Are services caring?

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, 85% said the last GP they saw was good at explaining tests and treatments which was the same as the CCG average and higher than the national average of 82%. Of those who responded 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78% and national average of 74%.

Similarly 82% patients said the last nurse they saw or spoke with was good at explaining tests and treatments and 72% said the last nurse they saw or spoke with was good at involving them in decisions about their care. These were both higher than the CCG average and national average.

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

The new patient questionnaire included the audit questions devised by the Alcohol Learning Centre as a test to identify alcohol use disorders (AUDIT-C).

The practice had access to Turning Point an open access integrated community based drug and alcohol service offering clinical and non-clinical support to patients with drug and alcohol problems, their carer's and family members.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 87% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86% and national average of 82%. Similarly 89% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80% and national average of 78%.

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.

The practice had access to 'Maze Advocacy' a local service for young people experiencing emotional and mental distress. It could also refer young patients to 2bU Somerset a service for young people who may find being gay or lesbian, transgender or questioning their sexuality difficult. Patients with eating disorders could be referred to the Somerset and Wessex Eating Disorders Association (SWEDA) for support.

Notices in the patient waiting room, on the TV screen and patient website also told patients how to access a number of support groups and organisations. The website included information supplied by NHS Choices. The practice's computer system alerted GPs if a patient was also a carer.

A member of administration staff had been identified as the Carers lead and kept a dedicated notice board up to date with information. They sign posted patients with caring responsibilities to sources of support.

There was a drop-in centre held within the practice when the 'village agent' would provide advice to patients who were having difficulty with bills provide advice on housing related issues.

Staff told us that if families had suffered bereavement, they were sent a sympathy card and their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. One of the comments cards we received reflected how a patient appreciated the care and efficiency shown by staff following bereavement.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

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

There were appointments reserved for emergencies each day. The practice had reduced waiting times from one or two weeks and routine appointments could now be in less than a week.

Feedback from the Patient Participation Group (PPG) in relation to delayed appointments led the partners to increasing the length of appointments from 10 to 15 minutes each.

The practice provided routine health checks on request including, blood pressure monitoring, urine testing and lipid profiling to assess cardio-vascular risk. The practice offered prostate specific antigen (PSA) screening on request to ensure male patients were properly informed.

The respiratory clinic was held on Friday afternoon and in the early evening to enable working patients and students with asthma to attend. There were also telephone reviews available for patients with stable, mild asthma.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). The practice had improved information for patients related to the on-line repeat prescription ordering process and included dedicated time each week for the carers champion to carry out this role.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities and older patients. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The practice had a stock of wheelchairs if patients required them on a temporary basis.

There were a small number of patients from the travelling community and we were told they received the same treatment as other patients. The practice maintained registers of those who were considered to be vulnerable such as those with poor mental health, patients with learning disabilities and children on the at risk register. There was a system for flagging vulnerability in individual patient records.

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

Access to the service

The practice was open from 9 am until 6.30 pm Monday to Friday. The telephone was manned by a member of staff from 8 am. Appointments were available from 9 am until 11.30 and from 4.40 pm until 6.10 pm Monday to Wednesday and from 2.30 until 6.10 pm on Thursday and Friday.

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

Longer, double, appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to two local care homes when patients needed one.

All patients had a named GP. Appointments were offered until 6.20 in the evening for patients who were in

Good

Are services responsive to people's needs?

(for example, to feedback?)

employment or education. Appointments and repeat prescriptions could be booked on-line and the on-site dispensary provided a 'one-stop' facility for provision of medicines at the time of consultation with a GP.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example, of those who responded 94% found it easy to get through to the practice by telephone compared to the CCG average of 76% and England average of 71%. In addition 82% were satisfied with the practice's opening hours compared to the CCG average of 77% and England average of 75%.

Similarly, 80% described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.

Comments received from patients showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice Most patients who completed comments cards were satisfied with the appointments system and said it was easy to use.

There were appointments available outside of school hours for children and young patients and in the evening for patients who were in employment or students. The online booking system was available and telephone consultations were available.

Listening and learning from concerns and complaints

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

There was a practice policy that informed staff on how to respond to complaints, comments and suggestions, including the procedure to follow. The complaints procedure was present as 'information to patient'. It contained and overview of the complaints process, local resolution, complaining on behalf of someone else and how complaints would be handled by the practice. It included the contact details of NHS England and The Parliamentary and Health Service Ombudsman and explained how patients could contact these organisations. The practice had a template to record stages in the process had been carried out, any arising actions and learning outcomes.

The practice had received two complaints during the last year. If patients had a grumble about waiting times for example, this was dealt with at the time. The complaints were recorded and showed the nature of the compliant, actions taken and outcome. One related to a misunderstanding over an appointment and the other was concerned with a relative of a patient who felt he was excluded from their parents care. The practice responded by sending an informative letter explaining the reasons.

We received completed Care Quality commission comments cards where patients shared their views. Several patients said they had no complaints

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 on the practice website. It stated "We make every effort to give the best service possible to everyone who attends our practice".

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them.

The practice business plan included obtaining mobile access to the electronic patient record system, federation developments and refurbishment of treatment room B. In addition there was a planned programme of policy review and exploration of how the practice could make use of social media.

Governance arrangements

There was a clear leadership structure with named members of staff in lead roles. The partners led in different areas. For example one of the partners was the lead for dispensing services and was the lead contact with the local medical committee. The other partner took overall responsibility for repeat prescribing. We spoke .with 10 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.

We found there to be a lack of leadership within the nursing team. The practice had had difficulty recruiting a nurse however they were awaiting a new nurse with leadership experience to commence work. The new nurse would take on a governance role within the nurse team. Recruitment of a new nurse would allow the practice to provide an increase in appointments for long term conditions.

Each morning, before patients arrived for appointments, all staff met in the reception area to discuss plans for the day. All of the GPs including the trainee doctor also met daily, during the coffee break. The practice manager met with the partners weekly. There were regular departmental meetings. For example, dispensing staff met monthly as did the nursing staff. There was a full practice meeting every month and the nursing team met with the GPs weekly.

A range of audits were conducted including an audit of cervical smear test results. One of the salaried GPs, the practice lead for contraception showed us the audit they completed in respect of contraceptive implants.

We looked at audits relating to the use of mood changing medicines in women of child bearing age, post-menopausal bleeding, diabetes management and atrial fibrillation (abnormal heart rate). We found the audits to be comprehensive with a programme of re-audits where changes had taken place.

Evidence from other data sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

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 and most staff had completed a cover sheet to confirm that they had read the policy and when. All nine policies and procedures we looked at had been reviewed annually and were up to date.

The GP and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Somerset Practice Quality Scheme to measure its performance. In 2014 GP practices within Somerset Clinical Commissioning Group undertook SPQS (Somerset Quality Practice Scheme), a local alternative to the national GP quality incentive scheme (QOF) which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. SPQS was introduced to assist practices to align their care with local priorities and to be more effective in helping those patients with complex needs.

The data for this practice showed it was consistently performing above national standards for managing some

Are services well-led?

Good

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

of the most common long-term conditions achieving 99% in many clinical areas and for the implementation of preventative measures. We saw that SPQS data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example, in respect of health and safety.

The practice manager was responsible for human resource policies and procedures. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. The practice had a virtual Patient Participation Group (PPG). It had 7 members, three of whom attended meetings regularly and four who did not attend the meetings but received information from the PPG by email. We met two members of the group. They told us one of the GPs and practice manager attended meetings.

We looked at the results of the PPG survey in the report submitted to the Clinical Commissioning Group in March 2015. It identified three priority areas the practice responded to. The report described the priorities for the practice, actions taken and resulting outcomes. One of the priorities was to improve the on-line repeat prescription ordering facility. The practice developed a step by step guide for patients and there were fewer queries and requests for help with the system.

We looked at the Friends and Family Test results and saw there had been 109 responses. Of these 93% said they would recommend the practice to friends and family and 3% indicated they would not recommend the practice. Two patients said they were 'unlikely' to recommend the practice, five patients did not indicate if they would, 27 said they were 'likely' to recommend the practice and 74 indicated they were 'extremely likely' to.

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 staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they had staff training afternoons once each month where guest speakers and trainers sometimes attended.

The practice was a training practice for medical students and GP trainees. At the time of our inspection the practice was supporting a GP registrar (ST3). We spoke to the GP registrar who praised the daily coffee break meetings with GPs as this allowed case discussions and support.

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, following one significant event when a dictated letter was mislaid, the practice introduced a dictation tracking system so any dictation tapes can be tracked in the practice.

One of the GPs was setting up a dispensing group ('dispensing anonymous') for local practices to share information. The aim of this group was to provide knowledge sharing, learning for incidents and alerts and a support network for dispensary staff.