# Pudding Pie Lane Surgery

## Quality Report

Mendip Vale Medical
Pudding Pie Lane
Langford
BS40 5EL
Tel: 01934839820
Website: www.mendipvale.nhs.uk

Date of inspection visit: 15th,16th and 17th August 2017
Date of publication: 23/10/2017

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 | Requires improvement |
| Are services safe? | Requires improvement |
| Are services effective? | Good |
| Are services caring? | Good |
| Are services responsive to people's needs? | Good |
| Are services well-led? | Inadequate |

# Summary of findings

## Contents


### Summary of this inspection

Page

Overall summary 2

The five questions we ask and what we found 4

The six population groups and what we found 7

What people who use the service say 11

### Detailed findings from this inspection

Our inspection team 12

Background to Pudding Pie Lane Surgery 12

Why we carried out this inspection 12

How we carried out this inspection 12

Detailed findings 15

Action we have told the provider to take 31


## Overall summary

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

We carried out an announced comprehensive inspection at Mendip Vale Medical Practice and its four branch sites on 15th, 16th and 17th August 2017. Overall the practice is rated as Requires Improvement.

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

- There was a system in place for reporting and recording significant events.
- The practice had systems to minimise risks to patient safety. However, these were not used consistently or embedded across the provider locations.
- Staff were aware of current evidence based guidance. Staff had been trained to provide them with the skills and knowledge to deliver effective care and treatment.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Relationships with care services and the support given to patients living in these care services had improved during the last six months.
- Information about services and how to complain was available. Some improvements were made to the quality of care as a result of complaints and concerns. However, there was an inconsistent approach to identifying trends, themes and responding to concerns raised.
- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities at two of the locations, and had contingency plans to improve these for patients who used the Congresbury, Yatton and Wrington. All the locations were well equipped to treat patients and meet their needs.
- There was a leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The provider was not always aware of the requirements of the duty of candour as there was an inconsistent approach to managing complaints and significant events investigations.

# Summary of findings

- The practice had not investigated under their Significant Events Analysis, complaints processes, or responded to under the Duty of Candour an event where a patient received a serious injury on the practice premises. The practice had not informed the CQC in a timely way via a Statutory Notification form of an event that was reported under RIDDOR( Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) in April 2017.

The areas where the provider must make improvements are:

- The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular, ensuring that appropriate Disclosure and Barring Service checks and training were in place for those staff carrying out chaperone duties.
- There was limited proper and safe management of medicines. In particular, stock medicines and the management of controlled and emergency medicines.
- There were no systems or processes that ensured the registered person maintained securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular, the management of prescription paper, prescription pads their security and ensuring there was a clear audit trail maintained.
- The registered person had systems or processes in place that operated ineffectively in that they failed to assess, monitor and improve the quality and safety of the services being provided. In particular, ensuring staff worked in accordance to policies relating to significant event analysis, emergency medicines, complaints, medicines management and health and safety.
- The practice had not investigated under their Significant Events Analysis, complaints processes, or responded to under the Duty of Candour an event where a patient received an injury on the practice premises.

In addition the provider should:

- Have infection prevention and control, hand washing and aseptic technique audits in place and have oversight of the immunisation status of all staff.
- Review the systems for holding data sheets in regard to Control of Substances Hazardous to Health kept at the practices.
- Ensure the regular fire drills are carried out for all staff at all of the locations.
- Review processes for checking emergency equipment.
- Ensure that non-clinical staff have the necessary training and guidance for the triage of patient's needs in regard to the urgency of being seen by a clinician.
- The provider should notify the commission without delay any incidents of serious injury to a service user (patient), such as a fall on the premises, which occurs whilst services are being provided.

**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?**

**Requires improvement**

The practice is rated as requires improvement for providing safe services.

- Staff understood their responsibilities to raise concerns, and to report incidents and near misses. However, there was an inconsistent approach to how they were reported, investigated and acted upon.
- The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular, ensuring that appropriate Disclosure and Baring Service checks and training were in place for those staff carrying out chaperone duty.
- There was limited proper and safe management of medicines. For example, stock medicines used for treatment at the locations and the management of controlled medicines in the dispensary at Pudding Pie Lane.
- Systems for infection prevention and control, recruitment, emergency medicines were not implemented fully and embedded. Fire procedures were in place but there was not a regular programme of fire drills and staff were not trained in the fire marshal roles.

**Are services effective?**

**Good**

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework showed patient outcomes were at or above average compared to the national average.
- Staff were aware of and used current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills and knowledge to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was coordinated with other services involved.

**Are services caring?**

**Good**

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.

# Summary of findings

- Survey information we reviewed showed that 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 accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

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

Good

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. Patients had access to extended hours appointments in early morning, late evening and Saturday morning.
- The practice took account of the needs and preferences of patients with life-limiting conditions, including patients with a condition other than cancer and patients living with dementia.
- Patients we spoke with said they found it easy to make an appointment with a named GP and 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.
- Information about how to complain was available and evidence from the examples reviewed showed the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders. However, this was not consistently applied or followed.

**Are services well-led?**

Inadequate

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

- The practice had a vision and a strategy and all staff were aware of this and their responsibilities in relation to it. There was a documented leadership structure, although some aspects of the governance and leadership were not fully embedded.
- The practice had a number of policies and procedures to govern activity, but some of these had not been implemented or embedded. In particular the management of prescription paper, prescription pads their security and ensuring there was a clear audit trail maintained.
- All staff had received inductions and had regular performance reviews and were able to attended staff meetings and events.
- The practice had systems or processes in place that were operating ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality

# Summary of findings

and safety of the services being provided. In particular, ensuring staff worked in accordance to policies relating to significant event analysis, emergency medicines, complaints, medicines management and health and safety.

- The practice had not investigated under their Significant Events Analysis, complaints processes, or responded to under the Duty of Candour an event where a patient received a serious injury on the practice premises. The practice had not informed the CQC via a Statutory Notification form of an event that was reported under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) in April 2017. During this inspection the practice submitted a Statutory Notification retrospectively.

# 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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as requires improvement for the safe domain and inadequate for well-led domain. The issues identified as requires improvement overall affected all patients including this population group. However, there were examples of good practice.

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may need palliative care as they were approaching the end of life. It involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.

### People with long term conditions

Requires improvement

The practice is rated as requires improvement for people with long term conditions. The provider was rated as requires improvement for the safe domain and inadequate for the well-led domain. The issues identified as requires improvement overall affected all patients including this population group. However, there were examples of good practice.

- Nursing staff had lead roles in long-term disease management and patients at risk of hospital admission were identified as a priority.
- Performance for diabetes related indicators was similar to the clinical commissioning group (CCG) and national averages. For example, the percentage of patients with diabetes, on the register, average blood sugar test was acceptable less in the preceding 12 months, was 80%, the CCG was 76% and the national average was 78%.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.

# Summary of findings

- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- All these patients had a named GP and there was a system to recall patients for a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

**Families, children and young people**

**Requires improvement**

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as requires improvement for the safe domain and inadequate forthe well-led domain. The issues identified as requires improvement overall affected all patients including this population group. However, there were examples of good practice.

- From the sample of documented examples we reviewed we found there were systems 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 accident and emergency (A&E) attendances.
- Immunisation rates were relatively high for all standard childhood immunisations.
- Patients told us, on the day of inspection, that children and young people were treated in an age-appropriate way and were recognised as individuals.

  Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice worked with midwives, health visitors and school nurses to support this population group. For example, in the provision of ante-natal, post-natal and child health surveillance clinics.
- The practice had emergency processes for acutely ill children and young people and for acute pregnancy complications.

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

**Requires improvement**

The practice is rated as requires improvement for the care of working age people (including those recently retired and students). The provider was rated as requires improvement for the safe domain and inadequate for the well-led domain. The issues identified as requires improvement overall affected all patients including this population group. However, there were examples of good practice.

# Summary of findings

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

**People whose circumstances may make them vulnerable**

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as requires improvement for the safe domain and inadequate for the well-led domain. The issues identified as requires improvement overall affected all patients including this population group. However, there were examples of good practice.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability. We were told 0.35% of their patients had an identified learning difficulty.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice had information available for vulnerable patients about how to access various support groups and voluntary organisations.
- Staff interviewed knew how to recognise signs of abuse in children, young people and adults whose circumstances may make them vulnerable. They were aware of their responsibilities regarding information sharing, documentation of safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

**People experiencing poor mental health (including people with dementia)**

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as requires improvement for the safe domain and inadequate for the well-led domain. The issues identified as requires improvement overall affected all patients including this population group. However, there were examples of good practice.

# Summary of findings

- The practice carried out advance care planning for patients living with dementia.
- The practice had a system for monitoring repeat prescribing for patients receiving medicines for mental health needs.
- Performance for mental health related indicators was similar to the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who have a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94%, the CCG 93% and the national average 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those living with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice had information available for patients experiencing poor mental health about how they could access various support groups and voluntary organisations.
- The practice had a system to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff interviewed had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The latest national GP patient survey results were published in July 2016. This information does not include data regarding the increased number of patients registered from the acquisition of St Georges Surgery in October 2016. The results showed the practice was performing in 2015/2016 in line with local and national averages. 216 survey forms were distributed and 129 were returned. This represented 0.6% of the practice's patient list.

- 94% of patients described the overall experience of this GP practice as good compared with the clinical commissioning group (CCG) average of 87% and the national average of 85%.
- 92% of patients described their experience of making an appointment as good compared with the CCG average of 93% and the national average of 92%.
- 89% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received 10 comment cards, of which eight were positive about the service overall and highly positive about the standard of care received from GPs and Nurses. Two of the comment cards had mixed comments and referred to problems obtaining appointments and dispensary errors since the amalgamation of services under Mendip Vale Medical Practice. We also received four comments from patients submitted through the CQC's Share your experience process. These were positive, with patients stating they felt their needs were met and staff were caring and helpful.

We spoke with 11 patients during the inspection including three members of the patient participation group. All patients said they were satisfied with the care they received and thought staff were approachable, they were given enough time and felt involved with their care. We spoke with three patients following the inspection who told us they felt their medical care was good.

We also spoke with two staff members of care services whose service users (patients) were in receipt of care and support from the practice. They told us the working relationship had improved in the last six months, patients were cared for and listened to, and their needs met.

The percentage of respondents to the GP patient survey (July 2016) who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area was 89% which was higher than the CCG average of 81% and the national average of 79%.

# Pudding Pie Lane Surgery

**Detailed findings**

## Our inspection team

**Our inspection team was led by:**

A CQC Lead Inspector**.** The team included a GP specialist adviser and two additional CQC inspectors.

## Background to Pudding Pie Lane Surgery

Mendip Vale Medical Practice, the registered main service is located in a residential area of Langford, North Somerset. Mendip Vale Medical Practice also provides full time services from three other locations and part time services from one location. Together the locations had approximately 25,000 patients registered from around the local and surrounding mainly rural areas including Blagdon, Churchill, Clavershamm , Cleeve, Congresbury, Hewish Kenn, Kensington Seymour, Langford, St Georges, Wrington and Yatton. Mendip Vale Medical Practice is the result of several local GP services contracts being taken over by one provider in October 2015 and October 2016.

The addresses from where the full time services are provided are:

Mendip Vale Medical (Langford)

Pudding Pie Lane

Langford

BS40 5EL

Mendip Vale Medical (Yatton)

155 Mendip Road

Yatton

BS49 4ER

Mendip Vale Medical (Congresbury)

Station Road

Congresbury

BS49 5DX

Mendip Vale Medical Practice (St Georges)

135 Pastures Avenue

St Georges

Weston Super Mare

BS22 7SB

The address from where the part time (as and when demand requires) services are provided is:

Mendip Vale Medical (Wrington)

2 Broad Street

Wrington

BS40 5NG

Two of the five Mendip Vale Medical Practices buildings, at Langford and St Georges, were purpose built in 2012/2013. The practice's buildings at Yatton and Congresbury are converted residential buildings with limited car parking. The Mendip Vale Medical Practice at Wrington, a part time service, is held in a former retail store with no car parking.

Patients can attend any of the practice locations and there is a dispensary at Langford. The practice is able to provide pharmaceutical services to those patients on the practice list who lived more than one mile (1.6km) from their nearest pharmacy premises.

The practice is a partnership of eight GP partners who employ 10 salaried GPs. Seven of the GPs are male and 11

are female. Not all of the GPs work across all locations. The practice was a GP training practice and supports medical students and GP trainees from the Severn Deanery. At the time of this inspection, there was one medical student and three GP trainees at the practice. The practice employed four Advance Nurse Practitioners who were also independent prescribers, 10 practice nurses and eight health care assistants. There was also one research nurse based at Langford. The practice has a practice manager who is also the CQC registered manager, and is supported by a team of management staff, reception staff, administrators and secretaries.

The practice locations at Langford, St Georges and Yatton are usually open from 8.00am to 6.30pm Monday to Friday. Extended hours appointments are from 6.30am each Tuesday at Langford and until 8pm on a Thursday at Yatton. Saturday surgeries are held each week at both Langford and St Georges from 9am until 12 midday. Congresbury practice is open from 8.30am until 1.30pm, Monday to Friday. The Wrington location is open on varied dates and times and patients have to contact the main surgery at Langford to check its availability.

The practice has a General Medical Services contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice is contracted to deliver for a number of enhanced services including; extended hours access for patients, childhood immunisations, enhanced services for the assessment and provision of services for patients living with dementia and the practice were involved in the unplanned hospital admission avoidance scheme.

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

Data from 2015/2016 that is available to the CQC shows:

The age of the patient population was broadly in line with national averages with the exception of 15-44 years old was 21% compared with the national average of 40%.

Other Population Demographics included 54% of the practice population had a long standing health condition, which was similar to the national average. Also 60% of patients were in paid work or full time education which was similar to the national average of 61.5%. Only 0.83% of the practice population was from a Black and Minority Ethnic background. Information from the

Index of Multiple Deprivation 2015 (IMD): showed the practice population is at 12.8% (the national average 21.8). The lower the number the more affluent the general population in the area, is.

Income Deprivation Affecting Children (IDACI): is 13% (the national average 19.9%)

Income Deprivation Affecting Older People (IDAOPI): is 9.7% (the national average 16.2%).

## Why we carried out this inspection

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice such as the findings and outstanding issues from previous inspections at the locations we were inspecting. These were inspections carried out prior to the locations and NHS England contracts being assimilated into the current organisation in October 2016 and the registration change with the Care Quality Commission in May 2017. We asked other organisations such as NHS England and the local clinical commissioning group to share what they knew. We carried out announced visits on the 15th, 16th and 17th August 2017.

During our visits we:

- Spoke with a range of staff including from the clinical practice team, five practice partners, five salaried GPs, two Advanced Nurse Practitioners, three practice nurses,

two health care assistants and two practice pharmacists. From the business administration team we spoke with the practice manager, who was also the CQC registered manager who is accountable and in day to day management of the service, the general manager and the three service managers. We spoke with a number of administration and reception staff at all of the locations. We also spoke with two members of the community health team who had regular contact with the practice, the community matron and a community nurse.

- Spoke with patients who used the service and the three members of the Patient Participation Group.
- Observed how patients were being cared for in the reception area and talked with carers and/or family members
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Visited all five practice locations
- Looked at information the practice used to deliver care and treatment plans.

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

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

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

- older people
- people with long-term conditions
- families, children and young people
- working age people (including those recently retired and students)
- people whose circumstances may make them vulnerable
- people experiencing poor mental health (including people living with dementia).

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

Requires improvement

# Are services safe?

## Our findings

**Safe track record and learning**

There was a system for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form did not guide staff to the reporting of notifiable incidents under the duty of candour as an action. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- From reviewing the 34 summary records submitted by the practice prior to the inspection, we found that when things went wrong with care and treatment, the practice used their significant event analysis (SEA) process to investigate. This process included ensuring patients were informed of the incident, what the practice had found during the investigation and what action they were taking to prevent the incident occurring again. However, on closer review of the information held at the practice and their complaints records, it could be seen that there was a variance in how staff were identifying what was a significant event, how they were investigated and how they were providing feedback to the people involved. We found that similar events were identified differently and there was no systematic identification of themes or trends. For example, the treatment necessary for patient care being missed because of scanning systems were not always effective. There was evidence that patients discharge letters or letters from consultations with external health care professionals were scanned and reviewed by a practice clinician in a timely way. We also found that staff were not always linking SEAs with complaints which had been received. For example, some prescription dispensing errors and referral delays were logged as a complaint but not raised as a significant event and significant events logged were not followed through and parts of the significant event were not investigated and responded to as part of the provider's complaints process. We saw that an incident of an injury that occurred on one of the practice's premises in April 2017 which was reported under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) but was not investigated under the SEA process.
- We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where significant events were discussed and actions put in place. For example, the minutes of one meeting showed the practice discussed a complaint regarding a patient being prescribed antibiotics they were allergic to. The practice identified that the detail of the patient's allergies was not clearly highlighted in their summary information. Changes were made to the method of recording patient's key information so that the risk could be reduced and flagged to clinical staff to prevent reoccurrence. There was no evidence these changes were reviewed or of on-going learning or any process to review that the changes had been implemented effectively. The practice's policy and procedure for SEAs was reviewed and updated during the inspection process to aid staff to apply consistent judgement to how issues were identified and reviewed.

**Overview of safety systems and processes**

The practice had some systems, processes and practices in place to minimise risks to patient safety. However, not all these systems had been fully implemented and embedded.

Arrangements for safeguarding reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding who had some oversight of patients at risk and provided support to colleagues when it was required. We were told that GPs took individual responsibility for responding to and monitoring their own patients who were at risk, attended meetings and shared information with colleagues when required. We were told 0.35% of their patients had an identified learning difficulty.

- Staff interviewed demonstrated they understood their responsibilities regarding safeguarding and had received training on safeguarding children and vulnerable adults relevant to their role. GPs and Advanced Nurse Practitioners (ANPs) were trained to child protection or child safeguarding level three.

Requires improvement

# Are services safe?

- Notices advising patients that chaperones were available if required were not on display in all of the locations. We also noted that not all treatment and consulting rooms had a copy of their notices that chaperones were available on display for patients to read. Some were under equipment or were kept in a locked drawer. Through discussion with GPs and other clinicians when a chaperone was required they sought assistance from reception staff or nursing colleagues. They also told us it was their understanding the staff had been trained for their role. We spoke to a variety of new and established reception staff who had all stated they had been asked to carry out this role. Staff gave differing accounts of how they were carrying out the chaperoning process and were not aware of the detail of the policy and procedure. None of the staff we spoke with could confirm they had received training for this activity. The practice could not confirm through looking at the organisations records that staff who acted as chaperones were appropriately trained for the role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

The practice maintained appropriate standards of cleanliness and hygiene.

- We observed the premises to be clean and tidy. There were cleaning schedules and monitoring systems in place. The organisation had engaged a contractor to clean all of the locations and this appeared to be working well. We found that although the provider had data sheets on site at all of the locations for the chemicals used by their staff in accordance with the Control of Substances Hazardous to Health Regulations 2002, the cleaning contractor did not. This was amended before the end of the inspection, with the cleaning contractor supplying the relevant data sheets for the chemicals they used.
- A member of the nurse team had recently been designated as the infection prevention and control (IPC) clinical lead, with an additional designated nurse lead at each location. There was no evidence that staff who had these lead roles or carried out the IPC audits had the appropriate level of training to do so.
- There was an IPC protocol and staff had received up to date basic training for infection prevention and control.
- Annual IPC audits had been undertaken by the general manager and from these audits we saw evidence that actions were identified to be taken to address any improvements required. However, we saw that these were not reviewed or updated to include when improvements had been completed. These audits were revisited and updated during the inspection process and showed that areas of concern had been addressed or had plans in place to be addressed.
- Nursing staff had cleaning schedules in place for equipment and clinical facilities, although the systems were slightly different across the locations. We noted that at one location (St Georges) the nursing staff used security tape to indicate the equipment was clean and ready for use, and to improve infection prevention and control.
- There were suitable systems and contracts in place for the management and disposal of clinical waste. Spill kits were available to staff at all of the locations. Detail had not been obtained of clinical staff's immunisation status other than their Hepatitis B immunisation. The practice had no knowledge of which staff would be compromised should there be an outbreak of infectious diseases such as measles, mumps or rubella.

The practice had arrangements for managing medicines, including emergency medicines and vaccines, in the practice to minimise risks to patient safety (including obtaining, prescribing, recording, handling, storing, security and disposal), however these were not consistently safe.

- There were processes for handling repeat prescriptions which included the review of high risk medicines. Repeat prescriptions were signed before being dispensed to patients and there was a reliable process to ensure this occurred. The practice carried out regular medicine audits with the support of the local clinical commissioning group pharmacy teams and their own pharmacists, to ensure prescribing was in line with best practice guidelines for safe prescribing.
- On 15 August 2017 the provider had implemented new processes for the security of blank prescription forms and pads and had introduced systems to monitor their use. However, we found that although a new policy and procedure and recording tools had been developed, the

process had not been adopted across all locations. We were told by one of the pharmacists employed by the practice that all new blank prescription forms and paper were received at the Langford location where they were logged and kept securely before being distributed to the other locations. We saw that prescription printer paper, when distributed to the other locations was logged as sent and received in accordance with the new policy at the Langford and St Georges locations. However, there was no record system found at the Yatton or Wrington locations.

- We found there was varied system of logging prescription paper to individual printers at all of the locations and there were no records prior to 15 August 2017 so that there was not a complete audit trail to assure the safety of prescription paper was not compromised. When speaking with staff we found there was an inconsistent approach to blank prescription paper security in printers in consulting rooms and treatments rooms across all of the locations. There was no audit check in place to see if these systems were being implemented consistently.
- We looked at how they managed blank prescription forms used for home visits (FP10NC) across all of the locations. We found the system at Langford did not ensure that blank forms could not be removed by unauthorised persons. Most of the logs used for monitoring the FP10NC forms related to 2014 or earlier. Only one entry in the log was signed as being removed. There was one pad printed with a GPs name which was correct for the end log date but the start numbers did not match up. There was no evidence the logs and prescription pads had been audited. There was no logging system at Yatton or Congresbury and St Georges had a different system.
- We found there was no consistent approach to logging and monitoring the blue blank prescription forms (FP10MDA) used for controlled medicines. Not all locations issued these and at Langford we were told one GP took the lead for the small number of patients requiring these types of prescriptions. We found there was a log to show the number of the blank prescription form logged out but no log of receipt of prescriptions into the practice or the start or end numbers since the pads had been received. At St Georges we found there were discrepancies in the numbers recorded and the actual pads as the numbers did not correlate and there was no audit process in place to check or monitor if there were any missing.
- At Yatton we found 15 pads with three GPs names on, one who had left the practice over a year ago. All of these pads had the previous providers name and address, not Mendip Vale Medical Practice and had not been returned to the supplier for destruction.
- There were four Advance Nurse Practitioners who could independently prescribe medicines for clinical conditions within their expertise. They received mentorship and support from the medical staff for this extended role. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health care assistants were trained to administer vaccines and medicines using patient specific directions (PSDs). PSDs are written instructions, from a qualified and registered prescriber for a medicine including the dose, route and frequency or appliance to be supplied or administered to a named patient after the prescriber has assessed the patient on an individual basis.
- There were medicines cupboards at four of the locations. No medicines were kept at Wrington. The contents of the medicines cupboards varied across the locations and the systems for stock checks and auditing were different. At two locations, Yatton and Congresbury, the medicines cupboards in the treatment rooms did not have a lock which made the medicines vulnerable to theft. When we raised this with the practice, actions were taken to remedy this to make them secure. There were no stock control or audits of medicines for these two locations. There were appropriate stock controls and monthly audits for medicines at Langford and St Georges. No controlled medicines were kept at any location with the exception of the dispensary at Langford.
- Langford had a dispensing service for patients who live more than 1.6 miles from a pharmacy. We checked their systems for managing medicines safety and how staff were supported to do so. We were told the practice had signed up to the Dispensing Services Quality Scheme (DSQS), which rewards practices for providing high quality services to patients of their dispensary. There was a named GP responsible for the dispensary and a

lead pharmacist had been assigned to maintain oversight of the service. All members of staff involved in dispensing medicines had received appropriate training and had undertaken continuing learning and development. Dispensary staff showed us standard operating procedures which covered aspects of the dispensing process (these are written instructions about how to safely dispense medicines). We saw evidence of regular review of these procedures and in response to incidents or changes to guidance in addition to annual review.

- There were systems were in place to ensure prescriptions were signed before the medicines were dispensed and handed out to patients.
- Dispensary staff identified when a medicine review was due and told us that they would alert the relevant GP or health care practitioner to re-authorise the medicine before a prescription could be issued. This process ensured patients only received medicines that remained necessary for their conditions.
- The dispensary staff highlighted all repeat prescriptions for high risk medicines to the GP prior to signing to ensure monitoring systems were in place and they were checked before the medicines were issued.
- We saw that errors in dispensing medicines were recorded and details were sent to the general manager who was responsible for ensuring there was an investigation and dealt with under their significant events process.
- The dispensary had no process for collecting near-miss error data and these were treated less formally and as such the practice was unable to identify potential areas for improvement to keep patients safe.
- We saw how medicines alerts were received into the practice and we were told about the processes of how they shared this information. There was a method of recording acknowledgement of the receipt of information, although this was not at an individual level and any action taken was only noted in practice clinical meetings minutes. We saw there were some audits carried out in regard to the dispensing practices, including a monthly check of uncollected prescriptions and how staff followed this through to check the wellbeing of the patient themselves. They usually sent a message to the GP concerned to alert them to the situation although there was no standard operating procedure to support this.
- We were told a member of staff took some repeat medicines to a local lunch club on a weekly basis to be collected by patients. However, there was no written guidance or protocol including keeping them at a safe temperature and no system of signing out or taking accountability for the medicines. There was no evidence the driver had appropriate training or had a Disclosure or Barring Service Check (DBS).
- Stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) were only held at the dispensing pharmacy at Langford and there were written procedures to manage them and for the destruction of controlled drugs. We looked at these systems and found some significant discrepancies in the record keeping and the audit and monitoring of these medicines. On 15 August 2017 we carried out a random check on the controlled medicines held in the controlled medicines cupboard. We found that where the log book stated there should have been 27 ampoules of Diamorphine (10mg), a strong pain-killing medicine, however we found 15 ampoules in stock. The practice did an immediate investigation the same day and reported to the appropriate authorities that there was a discrepancy. The practice told us and showed us evidence of a recording error from 25 August 2015 which they believed was the most likely cause. However, there was no clear evidence that appropriate audit and monitoring had taken place by the provider in the interim time that should have picked up this recording mistake.
- We did a further check on 16 August 2017 of all the medicines stored in the controlled medicines cupboard against that recorded in the controlled medicines log book. We were told the practice pharmacist had recorded they had carried out a complete check of these medicines earlier that day, however we found further inconsistencies. We found there were four 30ml bottles of morphine sulphate concentrated solution in the cupboard but no entry of receipt in the controlled medicines log book. We also found the log for the medicine Oxycodon 20mg tablets showed that 112 tablets had recently been received and entered in the

book. However, the person making the entry had put an '0' in the column to show the stock levels, which was incorrect. These concerns were highlighted to the management team and we were provided with information at the end of the inspection of some of the immediate steps the practice had taken in response to the concerns raised. We were provided with copies of the significant events forms developed for the recording of discrepancies in controlled medicines which showed their initial investigation outcomes and proposed actions to ensure safe management in the future. However, although requested we have no further evidence that any further investigations were undertaken or any actions taken have been sustained. We were also provided with copies of the reporting to NHS England, as they are required to, and NHS England's initial response to the reports being sent in.

We reviewed the systems and processes for recruitment and how the practice had ensured they had sufficient information and knowledge about the staff that had transferred over from previous locations.

- We saw that the practice had commenced to place key information and documents such as Disclosure and Baring Service (DBS) checks, references and identity information in their intradoc document management system. They also had hard copy files of personnel information and for new employees the detail of the recruitment process. We looked at four electronic and hard copy personnel files and found there was a variable amount and detail of information held. We saw evidence that appropriate recruitment checks had been undertaken prior to employment and recorded on file. For example, proof of identification, evidence of satisfactory conduct in previous employments in the form of references, and registration with the appropriate professional body. We saw that the appropriate checks through the DBS had been made for clinical staff and we were informed the practice had recently changed its protocol and was in the process of obtaining DBS checks for all staff although this was not completed. We noted the immunisation status of clinical staff was not checked in detail or in accordance with Public Health England guidelines, (The Green Book – immunisation for healthcare staff) such as childhood immunisations, Measles, Mumps and Rubella, and Chicken pox . The practice had checked Hepatitis B status but there was no written protocol on when this was to be rechecked. Copies of professional training certificates were not always retained in the personnel records. For example, the original qualification and any subsequent skills acquired such as for diabetes management. We saw that the practice ensured that applicants were interviewed by two of the practice lead staff who made interview notes that were kept on file. However, the name of the interviewer, date and decision to employ were not recorded.

**Monitoring risks to patients**

There were procedures for assessing, monitoring and managing risks to patient and staff safety, but these were not consistently safe.

- There was a health and safety policy available.
- The practice did not have up to date fire risk assessments for the Langford and Yatton locations. We raised this with the practice who updated these during our inspection. We saw the practice had documented fire evacuation processes available to staff for all of the locations, although we found these were not in every room of the buildings and did not include schematic plans of the layout of the buildings to show appropriate exit procedures. We noted that the fire evacuation risk assessments and plans did not include relevant detail for patients with reduced mobility or who used mobility aids.
- We saw that regular fire drills were not carried out across at all of the locations, none within the last 12 months. We were told these were planned to take place in the month of August. At Congresbury there was no fire alarm system and in response to our observations a fire drill at Congresbury was carried out on the 16 August with minor adjustments required to a fire drill card and the risk assessment to clarify information.
- There were designated fire marshals across the locations; although there was no contingency plans should they not be on duty. There was no detail of the any specific training they had been provided for this responsibility.
- The practice had a system to ensure that electrical and clinical equipment was checked and calibrated to ensure it was safe to use and in good working order. The

practice followed guidance from the Health and Safety Executive for the maximum timescale between testing of five years. They did a regular visual check on the health and safety monthly walk rounds.

- The practice had a variety of other risk assessments to monitor safety of the premises such as control of substances hazardous to health, infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- There were arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system to ensure enough staff were on duty to meet the needs of patients. GPs and other clinical staff were assigned duties and were flexible to the needs of the service and could be required at times to work at another location to provide clinical care. We were told the clinical support at all locations had been recently reviewed and changes implemented to ensure enough clinical staff were on duty. To enhance governance, a GP partner was assigned to a location and had oversight of clinical support for colleagues at that location. Advanced Nurse Practitioners (ANPs) and pharmacists had been employed recently to provide alternative clinical care for patients and we were informed that a further three clinicians would be joining the team by October 2017. We looked specifically at the clinical cover at St Georges as this was found previously at an inspection when it was a separate registered location, to not have sufficient staff on duty to meet the patient's needs. We saw there was a regular team of clinicians and there was a process of continuity of care for patients. Changes had been made recently and patients now had the flexibility of obtaining appointments with their preferred GP at the different locations.

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

The practice had arrangements to respond to emergencies and major incidents, but these were not consistently safe.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training and there were emergency medicines available in either the treatment rooms or at strategic points at each location.
- A defibrillator and oxygen with adult and children's masks were available at each location. First aid kits and accident books were available should they be required.
- Emergency medicines were easily accessible to staff in a secure area of the practice locations and all staff knew where to find them. However, we found that the range of emergency medicines kept at each site was slightly different and did not conform to the practices own policy and procedures. For example, we saw that all of the sites stocked rectal diazepam but this was not included in the practice policy list. We found rectal diazepam 2.5mg at the Congresbury location that was out of date in July 2017.
- The practice had a comprehensive business continuity plan for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.

Good

# Are services effective?

(for example, treatment is effective)

## Our findings

**Effective needs assessment**

Clinicians were aware of relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records. The practice used the clinical commissioning groups 'map of medicine' process to ensure their protocols and templates were used in the decisions and planning of patients care.

**Management, monitoring and improving outcomes for people**

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results from 2015/2016 which did not include information from the recently acquired St Georges location showed the practice had achieved 99% of the total number of points available compared with the clinical commissioning group (CCG) average of 97% and national average of 95%.

We were provided with the most up to date information regarding the practice's exception reporting. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects). The practice had identified a total of 205 patients during the year 2016/2017 that were excluded from their QOF data. Sixty three of these were patients living in a nursing or care home.

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2015/2016 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, the percentage of patients with diabetes, on the register, in which the last average blood sugar test was acceptable in the preceding 12 months, was 80%, the CCG average was 76% and the national average was 78%.
- Performance for mental health related indicators was similar to the CCG and national averages. For example, the percentage of patients with schizophrenia, bipolar affective disorder and other psychoses who had a comprehensive, agreed care plan documented in the record, in the preceding 12 months was 94%, compared to the CCG average of 93% and the national average of 88%.

There was evidence of quality improvement including clinical audit:

- There had been 12 clinical audits in the last two years, two of which were repeating cycles where the changes were implemented and monitored. One audit was to reduce the overprescribing of antibiotics generally, and the other audit looked at the prescribing of antibiotics for sore throat and tonsillitis. Both audits reviewed how effective the clinician's decision making was used in the best interests of the patient. We saw there was no planned programme or oversight of the clinical audits carried out.
- Findings were used by the practice to improve services. For example, recent action taken as a result included changes made to improve recording of consent for children under five in the patient's records. Also, the nursing team looked at wound care given during a specific time frame to check that patient's care was managed well. The outcome from the audit was that they implemented changes to better record in the patient's records regarding wound care. The practice now used specific coding to describe the type of wound and a recommended plan of care is followed consistently when different members of the nurse team provided treatment.

**Effective staffing**

Evidence from speaking with staff showed that staff had the skills and knowledge to deliver effective care and treatment. This including GPs with special interests in dermatology, musculoskeletal health, sports health and gynaecological health. Advance Nurse Practitioners (ANPs) and nursing staff had specialist skills to provide extra support for patients with heart failure, diabetes, and

Good

# Are services effective?

## (for example, treatment is effective)

asthma. Some members of the nursing team could offer implant fitting and contraceptive coil insertion. The practice was in the process of collating information of the specialist skills, qualifications and interests that staff had that would benefit their patients.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Some of the staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs and nurses. All staff had received an appraisal within the last 12 months. All staff that had previously worked at St Georges under a different provider had now had an annual appraisal and had access to supervisors and mentors as required.
- Staff received mandatory training that included: safeguarding, fire safety awareness, and basic life support and information governance. However, staff who undertook chaperoning and fire marshal roles had not had specific training to do so. Staff had access to and made use of e-learning training modules and in-house training. The practice had set up a special fund to support staff with access to additional training externally which was not part of the required training programme. However, we were not provided with detail of who had benefitted from this.

**Coordinating patient care and information sharing**

We looked at how patient care and information sharing was carried out with particular reference to the issues that had been highlighted in the complaints received and the issues raised as significant events during the last 12 months. We saw that there were key themes in these concerns relating to delays in referrals, reviewing of results and on occasion the sharing of information to other providers was incomplete. The practice had identified key areas of improvement which included:

- The management of care and risk assessments, care plans, medical records and investigation and test results. The practice had improved the scanning and coding of information received into the practice. A buddy system for clinicians had been introduced so that there were no delays in results being viewed in a timely way. Also there had been improvements in the quality of the record keeping in patient's records to share pertinent information between clinicians.
- The practice told us that 70% of all discharge from hospital letters were reviewed by clinicians and where necessary a follow up appointment arranged.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Information was shared between services, with patients' consent, using a shared care record.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

The practice supported 63 adult patients living in seven residential or nursing homes in the locality. We spoke with staff from two of these homes who said that the working relationship with the practice and the GPs has improved since the mergers, communications had improved, information was shared and they felt their service users (patients) received the care and support they needed. The GPs visited regularly on a planned basis and on a responsive basis whenever required.

**Consent to care and treatment**

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.

Good

# Are services effective?

## (for example, treatment is effective)

When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.

- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.

**Supporting patients to live healthier lives**

The practice identified patients who may be in need of extra support and signposted them to relevant services. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and people with dementia or memory loss.

The practice's 2015/2016 uptake for the cervical screening programme was 82%, which was comparable with the CCG average of 82% and the national average of 81%.

Childhood immunisations for 2015/2016 were carried out in line with the national childhood vaccination programme. Uptake rates for the vaccines given were comparable or above CCG/national averages. For example, rates for the vaccines given to under two year olds ranged from 92% to 96% and five year olds for MMR from 92% to 97%.

There was a policy to offer telephone or written reminders for patients who did not attend for their cervical screening test. There were failsafe systems to ensure results were received for all samples sent for the cervical screening programme and the practice followed up women who were referred as a result of abnormal results. The practice also encouraged its patients to attend national screening programmes for bowel and breast cancer.

Patients had access to the pilots the provider was participating in and research programmes if they wished. One recent pilot project aimed to empower patients to manage their own care for diabetes. Of the eight participants, six completed the programme and we were told continue to self manage their care with support from the practice.

Patients had access to appropriate health assessments and checks. These included health checks for new patients and NHS health checks for patients aged 40–74. For 2016/2017 the practice told us around 35% of patients who were offered took the opportunity to take these health checks. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

# Are services caring?

## Our findings

**Kindness, dignity, respect and compassion**

During our inspection we observed that members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Patients could be treated by a clinician of the same gender.

We received 10 comment cards, of which eight were positive about the service overall and highly positive about the standard of care received from GPs and Nurses. Two of the comment cards had mixed comments and included comments about problems obtaining appointments and dispensary errors since the amalgamation of services under Mendip Vale Medical Practice. We received four comments from patients submitted through the CQC's Share your experience process. These were positive, with patients stating they felt their needs were met and staff were caring and helpful. We spoke with 11 patients including three members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required. We observed that staff were very caring and we witnessed episodes of supportive actions to ensure their comfort. We saw, as normal routine across all locations, that clinicians collected patients and returned them to the waiting room, giving them time and assistance if required.

Results from the national GP patient survey, July 2016, which included information from St Georges, showed patients felt they were treated with compassion, dignity and respect. The practice was above average for its satisfaction scores on consultations with GPs and nurses. For example:

- 97% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 89% and the national average of 88%.
- 96% of patients said the GP gave them enough time compared to the CCG average of 88% and the national average of 86%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 93% and the national average of 92%
- 92% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 87% and the national average of 85%.
- 93% of patients said the nurse was good at listening to them compared with the CCG average of 92% and the national average of 91%.
- 96% of patients said the nurse gave them enough time compared with the CCG average of 93% and the national average of 91%.
- 99% of patients said they had confidence and trust in the last nurse they saw compared with the CCG average and the national average of 97%.
- 96% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 93% and the national average of 90%.
- 90% of patients said they found the receptionists at the practice helpful compared with the CCG average of 89% and the national average of 86%.

The percentage of respondents to the GP patient survey who stated that they would definitely or probably recommend their GP surgery to someone who has just moved to the local area was 89% which was higher than the CCG average of 81% and the national average of 79%.

The views of external stakeholders were generally positive and in line with our findings. We spoke with the community matron and staff from two care homes whose patients receive support from the practice. In general, we were told communication had improved with the community staff,

Good

# Are services caring?

although regular Multi-Disciplinary Team meetings needed to be developed further. For the care services, having the named GP, regular visits and the continuity of care was working well was working in the best interest of their service users (patients). They told us patients living in these services were listened to and the GPs took the time to talk to them.

**Care planning and involvement in decisions about care and treatment**

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

Children and young people were treated in an age-appropriate way and were recognised as individuals.

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

- 93% of patients said the last GP they saw was good at explaining tests and treatments compared with the CCG average and the national average of 86%.
- 90% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 84% and national average of 81%.
- 93% of patients said the last nurse they saw was good at explaining tests and treatments compared with the CCG average of 91% and the national average of 89%.
- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average 86% national average of 85%.

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

- Staff told us that interpretation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The Choose and Book service was used with patients as appropriate. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital.

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

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 862 patients as carers (3.4% of the practice list). Written information was available to direct carers to the various avenues of support available to them. Older carers were offered timely and appropriate support. A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

Staff told us that if families had experienced bereavement, their usual GP contacted them or sent them a sympathy card. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

Staff told us they had links with programmes in the local community and were in the process of developing a practice befriending service. They had also reviewed an ad hoc service started at St Georges to maintain communication with the 201 patients on their frailty register, patients who are isolated and who had complex needs. This was a regular telephone call to check their wellbeing. They told us they planned to roll this out across all of the locations. They told us they would train staff appropriately to signpost and safeguard patients and hopefully provide early intervention when required.

Good

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

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

The practice had an understanding of its population profile and had used this understanding to develop the services to meet the needs of its population:

- The practice offered extended hours on Thursday evenings until 8pm at Yatton, on Tuesday mornings from 6am at Langford and every Saturday morning between 8.30am and 12pm at Langford and on alternate Saturdays at St Georges for those patients who could not attend during normal opening hours.
- There were longer appointments available for patients with a learning disability and complex care needs.
- The practice had introduced an Urgent Care Team that included a duty doctor, Advance Nurse Practitioner and pharmacist. This offered a telephone triage and same day appointment system for patients with urgent needs.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice had recently introduced a new service whereby patients who were particularly vulnerable or had significant problems attending the practice were collected via the practice transport so that they did not miss appointments or treatment.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- The practice sent text message reminders of appointments and test results.
- Patients were able to receive travel vaccines available on the NHS as well as those only available privately.
- There were accessible facilities at Langford and St Georges, and limited access at Yatton, Congresbury and Wrington. The practice had access to a portable hearing loop held at Langford; there were no permanent facilities for this at any of the locations. Interpretation services were available via language line should it be required.
- The provider told us they were planning to build new premises at a new location for those patients who currently use Yatton, Wrington and Congresbury.

**Access to the service**

The practice locations were open between 8:30am and 6:30pm Monday to Friday. The exceptions were Congresbury, which closed each afternoon from 1:30pm,Wrington which opened at variable times for pre-booked appointments only. Early appointments from 6am were available at Langford every Tuesday; late appointments were available Thursday evening until 8pm at Yatton. Saturday appointments were available between 8:30am and 12pm at Langford every week and on alternate weeks at St Georges. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments were also available for patients that needed them.

Results from the national GP patient survey July 2016 showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 75% of patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 77% and the national average of 75%.
- 87% of patients said they could get through easily to the practice by phone compared to the CCG average of 70% national average of 72%.
- 79% of patients said that the last time they wanted to speak to a GP or nurse they were able to get an appointment compared with the CCG average of 76% and the national average of 75%.
- 91% of patients said their last appointment was convenient compared with the CCG average of 93% and the national average of 91%.
- 79% of patients described their experience of making an appointment as good compared with the CCG average of 74% and the national average of 73%.

However, one indicator was below local and national comparisons.

- 45% of patients said they don't normally have to wait too long to be seen compared with the CCG average of 55% and the national average of 57%.

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

Waiting times were also reflected in complaints. Thirteen of the 122 recorded complaints received at the practice were in regard to access to appointments. We spoke with patients and members of the Patient Participation Group who reported that waiting times appeared to be improving with the introduction of the Urgent Care process that had been set up where patients had access to on the day consultation and treatment. From patients feedback we found one area where patients still found problems; this was making appointments in advance with the GP of their choice.

The practice had recently implemented a different system to assess:

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

The practice had recently invested in a new telephone system and had call centres based at St Georges and Yatton, to receive patient calls for booking appointments and checking results. We spent time at both locations observing calls and speaking to staff. At these locations there was a dedicated team of staff answering calls, assessing the request from the patients or caller and redirecting to the appropriate person or service. Staff requested basic information from the caller, so staff were able to book the appropriate practitioner for this. In regard to requests for same day appointments or home visits, information was requested from the caller in regard to their needs, a brief summary logged of their requests and the request passed to a member of the Urgent Team including an Advance Nurse Practitioner, duty doctor, and pharmacist dependent on their need. We found there was no formal guidance or pathways to aid this decision making for non-clinical staff. Which meant that patients needs may be missed. When the request was received by the member of the Urgent Care Team they reassessed their request by telephoning the patient or carer to gather information to allow for an informed decision to be made on prioritisation according to clinical need. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made.

It was evident that, even with all the staff changes that have occurred, staff continued to have good knowledge of individual patients. We were given information to this effect in regard to an incident that occurred recently at St Georges. A nurse had become concerned that one of the elderly patients had not arrived for an appointment. They had tried to telephone the patient but couldn't get a reply. Two members of staff went to check at the person's home and found that they had fallen and called 999 and waited with the patient until the emergency services arrived.

**Listening and learning from concerns and complaints**

The practice had a system 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. Posters, leaflets and information on the practices website directed patients of how to make a complaint.

We looked at a sample of the 122 complaints received between 1 April 2016 and 15 August 2017 which included those complaints in regard to St Georges from October 2016 when the practice obtained the NHS Contract. We found, like the significant events reporting, there was not a consistent method of reporting concerns and complaints and there were missed opportunities to investigate some issues under the significant events analysis process. We also found that although records show concerns and complaints were investigated and the complainant informed of the outcome, there were inconsistencies in how they were investigated and actions put in place. We noted there was a large variation in assessing the complaint type, such as administration issues where the concern or complaint was in part more in regard to staff attitudes. We found that where some elements of complaints resulted in actions implemented they were recording them as not partially upheld. We saw that lessons were learned from individual concerns and complaints and information shared at the practice meetings to improve the service and outcomes for patients. However, the variances in the recording and monitoring of complaints and concerns impacted on the analysis of trends which was a missed opportunity at an earlier point to put further actions in place and prevent reoccurrence. For example, errors in patients being booked incorrectly to

Good

# Are services responsive to people's needs?

## (for example, to feedback?)

see a practitioner who did not provide the treatment they required. Another example was delays in scanning information into patient records meant that information in was not dealt with in a timely way.

The practice, up to recently, had not had a system of logging or monitoring positive feedback centrally, mostly sharing the information to the individual or at practice meetings and had just instigated a process to look at trends and themes raised.

# Are services well-led?

Inadequate

(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 as a primary care health team to deliver to all registered patients a personal healthcare service of the highest possible quality and to seek continuous improvement in the health status of the practice population overall, however the systems in place did not consistently support the practice to achieve these aims.

- Staff knew and understood the values.
- The practice had a strategy and had developed supporting business plans which reflected the vision and values and were regularly monitored.

**Governance arrangements**

The practice was in the process of aligning governance structures between each of the services that had merged since 2015. We found that they had brought some aspects together, this was still in progress with some of the structures and procedures still to be developed or embedded:

- There was a staffing structure and staff were aware of their own roles and responsibilities. Some of the GPs and nurses had lead roles in key areas, such as IT, clinical governance, safeguarding, infection control and medicines management. However, there were areas where lead roles and responsibilities were still under development or not yet embedded, such as nurse leads, health and safety and oversight of the dispensary.
- Practice specific policies were available to all staff. These were updated and reviewed regularly. However, we found that they were not always followed, such as medicines management, prescription security and the use of chaperones. We also found that there was no focused audit programme to check that staff were compliant with the provider's policies and procedures or with other legislation such as that for controlled medicines.
- The partnership had oversight of the performance of the practice, such as achieving and meeting patient's needs. Practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice.
- The practice had carried out clinical audits but did not have full oversight and were in the process of ensuring there was a regular programme of continuous clinical audit.
- The practice had not fully developed a system to ensure Diclosure and Barring Service checks were regularly carried out on the staff who had specific roles such providing clinical care or chaperone duties.
- The process for ensuring the practice had oversight of the immunisation status of staff needed to be fully implemented and embedded so that they had knowledge of which staff would be compromised should there be an outbreak of infectious diseases such as measles, mumps or rubella.
- For some areas of health and safety there were temporary arrangements for identifying, recording and managing risks, issues and implementing mitigating actions, however these were not consistently effective. Members of the management team were undertaking these lead roles such as fire safety, health and safety and infection control monitoring whilst staff were in process of being assigned these roles or being provided with training to carry them out; however, there were no processes in place to cover their absence.
- We saw evidence from minutes of meetings that time was allowed during these meetings for lessons to be learned and shared following significant events and complaints.

**Leadership and culture**

On the day of inspection the partners in the practice told us how they aimed to have the systems in place to demonstrate they had the capacity and capability to run the practice. They told us and showed us they prioritised safe, high quality and compassionate care and aimed to ensure this was delivered. Staff told us the partners and management were ensuring that that they had systems in place to support team building, such as various regular meetings, social activities, staff news letters to ensure that staff felt they were approachable and took the time to listen to all members of staff.

The provider was not always aware of the requirements of the duty of candour:

- There was an inconsistent approach to managing complaints and significant events investigations.

# Are services well-led?

Inadequate

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

- The practice had not investigated under their Significant Events Analysis, complaints processes, or responded to under the Duty of Candour an event where a patient received a serious injury on the practice premises. The practice had not informed the CQC via a Statutory Notification form of an event that was reported under RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995) in April 2017. During this inspection the practice submitted a Statutory Notification retrospectively.

There was a leadership structure and staff told us they felt supported by management.

- We saw the practice held and minuted a small number of multi-disciplinary meetings including with community matron and social workers to monitor vulnerable patients. We were told they were building on a regular programme of meetings and developing relationships across the different areas to ensure continuity and sharing of information. Where required, GPs met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes of these meetings were comprehensive and were available for practice staff to view. We were informed that there were GP away days. Whole practice team activities took place such as a recent summer party to enable team building. The practice had instigated a staff recognition award, 'Living the values' where other staff nominated someone on a monthly basis who has demonstrated the Mendip Vale Medical Practice values.
- All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

The practice encouraged and valued feedback from patients and staff. It sought feedback from:

- patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the PPG recently undertook an investigation into the prescription process. The aim of this investigation was to support the practice to increase patient use of the online repeat prescription process and to encourage patients to use the regular dispensing process. The aim was to reduce the timescales and volume of activity needed by the practice to fulfil patients requests in a more timely and effective way. The PPG told us they felt their voice was listened to and acted upon. They had been involved in the consultation processes the practice used for developing new services, for example the planning of a new building to replace Yatton and Congresbury.
- patients through public consultation meeting about the development plans for the service, what patients would like to see from their GP service.
- the NHS Friends and Family test, complaints and compliments received.
- staff through appraisal and team meetings. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

**Continuous improvement**

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. The practice had participated in pilots through a local consortium of GPs to encourage patients with diabetes to take the lead in managing their care, physiotherapy, community psychiatric nurse and web GP consultations. The practice told us how they were accessing training for improving staff skills for their telephone service and supporting staff to have additional skill in detecting and managing mental health problems.

The practice had recognised the facilities of Yatton, Congresbury and Wrington did not meet current good practice guidelines and limited the quality and diversity of services they could offer their patients at these locations. They had plans to build new facilities from which they could deliver and develop future services for patients.

This section is primarily information for the provider

# Requirement notices

## Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment<br>**How the regulation was not being met:**<br>• The registered persons had not done all that was reasonably practicable to mitigate risks to the health and safety of service users receiving care and treatment. In particular ensuring that appropriate Disclosure and Baring Service checks are in place for those staff carrying out chaperone duty.<br>• There was no proper and safe management of medicines. In particular stock medicines and the management of emergency and controlled medicines. |

| Regulated activity | Regulation |
|---|---|
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 17 HSCA (RA) Regulations 2014 Good governance<br>**How the regulation was not being met:**<br>• There were no systems or processes that ensured the registered person maintained securely such records as are necessary to be kept in relation to the management of the regulated activity or activities. In particular the management of prescription paper, prescription pads their security and insuring there was a clear audit trail.<br>• The registered person had systems or processes in place that operated ineffectively in that they failed to enable the registered person to assess, monitor and improve the quality and safety of the services being provided. In particular ensuring staff worked in accordance to policies relating to significant event analysis, complaints, chaperone, medicines management, fire and health and safety. |

This section is primarily information for the provider

# Requirement notices

| Regulated activity | Regulation |
| --- | --- |
| Diagnostic and screening procedures<br>Family planning services<br>Maternity and midwifery services<br>Surgical procedures<br>Treatment of disease, disorder or injury | Regulation 20 HSCA (RA) Regulations 2014 Duty of candour<br>**How the regulation was not being met:**<br>The registered person had failed to act in an open and transparent way with relevant persons in relation to care and treatment provided to service users in carrying on a regulated activity. In particular:<br>**Regulation 20(1)**<br>• The practice had not investigated under their Significant Events Analysis, complaints processes, or responded to under the Duty of Candour an event where a patient received a serious injury on the practice premises. |