Dr Sewell, Piotrowski & Yick

Quality Report

Mount Street,
Bishops Lydeard,
nr Taunton,
Somerset.
TA4 3LH
Tel: 01823 432361
Website: www.quantockvalesurgery.nhs.uk

Date of inspection visit: 9 June 2015
Date of publication: 30/07/2015

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Quantock Vale Surgery on 9 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well-led services. It was also good for providing services for older patients, patients 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 and people experiencing poor mental health (including people with dementia).

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

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

Summary of findings

- The practice proactively sought feedback from staff and patients, which it acted on.

We saw areas of outstanding practice including:

- The practice had a robust and secure model to deliver dispensary services to its patients. Every prescription, new or repeat, was clinically checked by the pharmacist against the clinicians' record. If changes were required the pharmacist would discuss these with the prescribing clinician before phoning the patient and arranging a face to face meeting with them to explain the change in detail.
- One of the nurses from the practice had initiated a swimming group for patients diagnosed with diabetes who were overweight and who were conscious of their body image. The group was currently supported and led by one of the patient participation group committee.
- Young person's appointments were available with the nurse practitioner where young patients could discuss contraception and receive sexual heath advice and information in confidence. The practice had signed up to provide free condoms through the national 'C' card scheme.
- The practice was part of a locally based project, called the Symphony project, which was aiming to provide enhanced support to patients with three or more diagnosed conditions.

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

Importantly, the provider should:

- Review staff awareness of the Mental Capacity Act 2005 and establish an agreed process for recording how best interest decisions are reached.
- Review how best interest decisions can be consistently recorded in patients notes.

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

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

Are services effective?

Good

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

Are services caring?

Good

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

Are services responsive to people's needs?

Good

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

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

One of the practice GPs was a provider of food bank vouchers. A small number of patients were now being supported through this support.

Are services well-led?

Good

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

Summary of findings

The six population groups and what we found

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

Older people

Good

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

People with long term conditions

Good

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

One of the nurses from the practice had initiated a swimming group for patients diagnosed with diabetes who were overweight and who were conscious of their body image. The group was currently supported and led by one of the patient participation group committee.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and community based services.

Summary of findings

Young person's appointments were available with the nurse practitioner where young patients could discuss contraception and receive sexual heath advice and information in confidence. The practice had signed up to provide free condoms through the national 'C' card scheme.

Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. It had carried out annual health checks for people with a learning disability and the majority of these patients had received a follow-up appointment. It offered longer appointments for people with a learning disability. One of the practice GPs was a provider of food bank vouchers. A small number of patients were now being supported through this support.

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

People experiencing poor mental health (including people with dementia)

Good

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

Summary of findings

experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health.	

Summary of findings

What people who use the service say

We spoke with ten patients visiting the practice during our inspection, two members of the patient participation group and received 30 comment cards from patients who visited the practice. We also spoke with two relatives of patients who lived in a nursing home as well as the patients themselves. We saw the results of the last Patient Participation Group report dated 30 March 2015. The practice also shared their findings from the current 'friends and family' survey for the practice. We looked at the practice's NHS Choices website to look at comments made by patients (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent National GP patient survey published on 8 January 2015 and the Care Quality Commission's information management report about the practice.

The majority of comments from patients were positive and praised the GPs and nurses who provided their treatment. For example; about receiving prompt care and treatment when required, about seeing the same GP when requested and about being treated with respect, compassion and concern. Other comments included statements about the responsiveness of the practice in providing appointments with their preferred GP or nurse, compliments about the appointment system, GPs helping patients to understand their condition and how they received effective treatment during life threatening illnesses. The patient participation group members we met spoke positively about the engagement shown by the relatively recently appointed practice manager and about how responsive the practice was to their suggestions for improvement.

We heard and saw how patients found access to the practice and appointments easy and how telephones were answered after a brief period of waiting. Comments from the National GP Patient Survey indicated 93% of patients saying it was easy to get through by telephone compared to the Clinical Commissioning Group (CCG) average of 77%. The most recent GP survey showed 98% of patients found the appointment they were offered was convenient for them. Patients also told us they used the practices online systems to arrange repeat prescriptions.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was generally private enough for most discussions they needed to make. Patients told us about GPs supporting them at times of bereavement and providing extra support to carers. A large number of patients had been attending the practice for many years and told us about how the practice had grown, they said they were always treated well and received good care and treatment. The GP survey showed 89% of patients said the last GP they saw or spoke with was good at giving them enough time and 84% said the GP treated them with care and concern which were better than the national average figures.

Patients told us the practice was always kept clean and tidy and periodically it had been refurbished, extended and updated. Patients told us that during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and that examination couches were covered with disposable protective sheets. Information from the National GP Patient Survey showed 94% of patients described their overall experience of this practice as good which was better than the national average of 85%.

Areas for improvement

Action the service SHOULD take to improve

- Review staff awareness of the Mental Capacity Act 2005 and establish an agreed process for recording how best interest decisions are reached.
- Review how best interest decisions can be consistently recorded in patients notes.

Summary of findings

Outstanding practice

We saw areas of outstanding practice including:

- The practice had a robust and secure model to deliver dispensary services to its patients. Every prescription, new or repeat, was clinically checked by the pharmacist against the clinicians' record. If changes were required the pharmacist would discuss these with the prescribing clinician before phoning the patient and arranging a face to face meeting with them to explain the change in detail.
- One of the nurses from the practice had initiated a swimming group for patients diagnosed with diabetes who were overweight and who were conscious of their body image. The group was currently supported and led by one of the patient participation group committee.
- Young person's appointments were available with the nurse practitioner where young patients could discuss contraception and receive sexual heath advice and information in confidence. The practice had signed up to provide free condoms through the national 'C' card scheme.
- The practice was part of a locally based project, called the Symphony project, which was aiming to provide enhanced support to patients with three or more diagnosed conditions.

Dr Sewell, Piotrowski & Yick

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector**.** The team included a GP, a practice manager and a practice nurse.

Background to Dr Sewell, Piotrowski & Yick

The practice of Drs Sewell, Piotrowski & Yick, Quantock Vale Surgery, Mount Street, Bishops Lydeard, Taunton, Somerset. TA4 3LHis located about 6 miles West of the centre of Taunton. The premises were built in the early 1970's and have been extended twice; the most recent extension in 2000 included a practice pharmacy. The practice has approximately 5,550 registered patients. The practice area stretches from Crowcombe in the north, to Tolland in the west, Oake and Norton Fitzwarren in the south and Kingston St Mary and the outskirts of Taunton in the east. The practice works within Somerset Clinical Commissioning Group (CCG), which is responsible for the provision of health care throughout Somerset. The practice is also part of the Taunton Deane Federation of GP practices; the GP practices in Taunton have come together to work collaboratively in commissioning health services for the population in this area.

There are three GPs and a team of clinical staff including a nurse practitioner, three practice nurses and a phlebotomist. One GP is female and two are male, the hours contracted by GPs are equal to three whole time equivalent employees. Collectively the GPs provide 24 patient sessions each week in addition they also provide extended hours for patients. Additionally the four nurses employed equal to 1.93 whole time equivalent employees. Non-clinical staff include secretaries, support staff and a small management team including a practice manager and practice assistant/medical secretary.

The practice population ethnic profile is predominantly White British and amongst the most affluent. There is a practice age distribution of male and female patients' broadly equivalent to national average figures. However the 15 to 39 year age groups numbers of patients is slightly below national average figures and the 55 to 69 age groups are slightly above national average. There are about 2.4% of patients from other ethnic groups. The average male life expectancy for the practice area is 80 years compared to the National average of 79 years; female life expectancy is 84 years compared to the National average of 83 years.

The National GP Patient Survey published in January 2015 indicated just over 83% of patients said they would recommend the practice to someone new to the area. This was slightly above the Somerset Clinical Commissioning Group average of 82.7%. Local Public Health statistics (January 2014) demonstrate that Quantock Vale surgery has a relatively low level of social deprivation, the Index of Multiple Deprivation being 12.5 when compared to a England average of 23.6; the Somerset average is 16.9 and anecdotally the rural population is asset rich but cash poor.

The practice has a General Medical Services (GMS) contract to deliver health care services; the contract includes enhanced services such as extended opening hours, childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia and minor surgery services. It also provides an influenza and pneumococcal immunisations enhanced service. These contracts act as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

Detailed findings

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by South Western Ambulance Service NHS Foundation Trust and patients are directed to this service by the practice during out of hours.

Why we carried out this inspection

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

How we carried out this inspection

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

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

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

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

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations such as the Somerset Clinical Commissioning Group (CCG) and Healthwatch to share what they knew. We asked the provider to send us information about their practice and to tell us about the things they did well. We reviewed the information for patients on the practices website and carried out an announced visit on 9 June 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included two GPs, the locum GP, the nurse practitioner two practice nurses, the phlebotomist, the practice pharmacist, the practice manager and four administrative and reception staff. We spoke with two members of the patient participation group, ten patients and received comment cards from a further 30 patients. We also spoke with staff, patients and relatives from a local nursing home the practice provided weekly support to.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, where it was identified that a prescription had gone missing.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last 15 months. The evidence we saw showed the practice had managed these consistently over time, had discussed and reviewed them monthly and could demonstrate evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of eight significant events that had occurred during the last 15 months and saw this system was followed appropriately. Significant events were a standing item on the weekly clinical meeting agenda and a dedicated meeting was held annually to review actions from past significant events and complaints. There was evidence that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms on the practice intranet and sent completed forms to the practice manager. They showed us the system used to manage and monitor incidents. We tracked eight incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared for example, encouraging patient adherence when taking medicines. Where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by both the practice manager and the practice pharmacist via email to relevant practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care they were responsible for. They also told us alerts were routinely discussed at clinical meetings to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

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

The practice had appointed a dedicated GP with lead responsibility for safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who the lead GP was and who to speak with in the practice if they had a safeguarding concern. We saw from records and minutes that regular monthly meetings were held to review safeguarding concerns. The GP with lead responsibility also attended local authority safeguarding meetings and shared information from these meetings with relevant staff.

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

There was a chaperone policy, which was visible on the waiting room noticeboards and in consulting rooms and on

the practice web site. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff had been trained to be a chaperone. Reception staff would act as a chaperone if nursing staff were not available. Receptionists had also undertaken training and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (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).

GPs were appropriately using the required codes on their electronic case management system to ensure risks to vulnerable patients, children and young people who were looked after or on child protection plans were clearly flagged and reviewed. The lead safeguarding GP was aware of vulnerable children and adults and records demonstrated good liaison with partner agencies such as the police, the mental health team and social services. We saw an example of these contacts during our inspection. Staff were proactive in monitoring if children or vulnerable adults attended accident and emergency or missed appointments frequently. These were brought to the GPs attention, who then worked with other health and social care professionals to ensure patient safety. We saw minutes of meetings where vulnerable patients were discussed. There was a system in place via the GPs and practice pharmacist for reviewing repeat medicines for patients with co-morbidities or for those who took multiple medicines.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed fridge temperature checks were carried out by the nurses alongside an electronic temperature log device which ensured medicines were stored at the appropriate temperature.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data and where significant events involved medicines or prescriptions. For example, patterns of antibiotic, hypnotics and sedatives and anti-psychotic prescribing within the practice.

There was a system in place for the management of high risk medicines such as warfarin and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results. We checked two anonymised patient records which confirmed that the procedure was being followed.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). The pharmacist carried out regular audits of the prescribing of controlled drugs on behalf of the practice. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated on 8 June 2015. We saw evidence that nurses had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a patient specific direction from the prescriber. A member of the nursing staff was qualified as an independent prescriber and they received regular supervision and support in their role as well as updates in the specific clinical areas of expertise for which they prescribed.

Good

Are services safe?

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency annually reviewed.

The practice had a robust and secure model to deliver dispensary services to its patients. The practice employed a pharmacist and dispensing team, who were co-located adjacent to the surgery (the buildings are joined and staff have internal access; there are separate public entrances). The pharmacist was also the prescribing advisor for the practice. They had daily contact with the clinical team to ensure best practice prescribing and both safety and quality for the patient is maintained. In addition the pharmacist had formal monthly meetings with the GPs to discuss and implement any general prescribing changes. The dispensary team had access to patients' clinical records and every prescription, new or repeat, was clinically checked by the pharmacist against the GPs patient record. If changes were required the pharmacist would discuss these with the prescribing clinician before phoning the patient and arranging a face to face meeting with them to explain the change in detail.

If a patient presents at the pharmacy requiring help or advice with a problem that the pharmacist was unable to solve, they will immediately discuss with the duty doctor or if required make an urgent GP appointment so the patient had a solution to their problem in a very timely way.

The dispensary audits all changes in prescribing to ensure both safety and quality for patients were maintained and balanced against cost effectiveness.

We saw a positive culture in the practice for reporting and learning from medicines incidents and errors. Incidents were logged efficiently and then reviewed promptly. This helped make sure appropriate actions were taken to minimise the chance of similar errors occurring again.

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

Cleanliness and infection control

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

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. For example, during intimate examinations. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the lead had carried out audits and any improvements identified for action were completed on time. The last audit had been carried out on 4 June 2015. Minutes of practice meetings showed the findings of the audits were discussed; the most recent audit was on the agenda for the next meeting.

We noted the premises were generally in good repair with most surfaces clean and undamaged and flooring intact. However, we saw a small area of flooring in one of the treatment rooms had started to lift and a section of wall near a door was damaged. We saw these were on the maintenance log and arrangements had been made for them to be repaired.

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

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw records confirmed the practice was carrying out checks in line with this policy to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was April 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, nebulisers, blood pressure measuring devices and the fridge thermometer; all had been recalibrated in April 2015.

Staffing and recruitment

The practice had a robust and thorough recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

Monitoring safety and responding to risk

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

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with the premises were monitored daily by staff at the end of each day and a 'premises incident reporting book' was kept to log any concerns or damage. The practice manager followed up on the log entries and arranged for repairs and maintenance. Risks associated with service and staffing changes (both planned and unplanned) were included on the log. We saw an example of this and the mitigating actions that had been put in place. For example, the use of named locum staff. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions and clear care plans where the patient was at risk of a hospital admission. Staff gave us examples of referrals made for patients whose health deteriorated suddenly, patients we spoke with confirmed these took place. Staff gave examples of how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. We saw an example of this during our inspection.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was

Good

Are services safe?

available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly. We checked that the pads for the automated external defibrillator were within their expiry date. The locations of all emergency equipment and medicines were clearly indicated and were easily accessible to staff.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines and associated equipment we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the utility companies to contact if the heating, lighting or water systems failed. The plan was last reviewed in 2015

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

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

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

The GPs told us they had lead responsibility in specialist clinical areas such as diabetes, heart disease and asthma and the nurses supported this work, which allowed the practice to focus on specific conditions. GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines, for example, for the management of respiratory disorders. Our review of the clinical meeting minutes confirmed that this happened.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that after patients were discharged from hospital they were followed up where required to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

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

The practice showed us 19 clinical audits that had been undertaken in the last two years. Just over a third of these were completed audits over two cycles where the practice was able to demonstrate the changes resulting since the initial audit. For example, following medicines guidance an audit was carried out on the use of medicines which are used in neuropathic pain. The initial audit in 2013 showed 88% of patients using the medicine were on an optimised dose. Following actions by the practice, a second audit in 2015 showed improvements and 98% of patients now received an optimised dose.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF) or Somerset Practice Quality Scheme (SPQS). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. SPQS is a locally based scheme aimed at improving services based on local patient's needs). For example, we saw an audit regarding the prescribing of analgesics and nonsteroidal anti-inflammatory drugs. Following the audit, the GPs

Good

Are services effective?

(for example, treatment is effective)

carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice to ensure it aligned with national guidelines. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

The practice also used the information collected for the QOF, SPQS and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets, It achieved 73.5% of the total QOF target in 2014, which was below the national average of 94.2%. This was accounted for by the practice participating in the Somerset Practice Quality Scheme (SPQS) and therefore was not providing all QOF data. Specific examples to demonstrate this included, Performance for diabetes related indicators was similar to the national average in most areas. The percentage of patients with hypertension having regular blood pressure tests was similar to the national average. The dementia diagnosis rate was comparable to the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures and we saw action plans setting out how these were being addressed.

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

The practice's prescribing rates were also similar to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP; this work was supported by the practice pharmacist. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the gold standards framework for end of life care. They had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. As a consequence of staff training and better understanding of the needs of patients, the practice was better able to support patients nearing the end of their life.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups. For example, patients diagnosed with learning disabilities. Structured annual reviews were also undertaken for people with long term conditions such as, diabetes, chronic obstructive pulmonary disease (COPD) and heart failure. We were shown data that approximately 90% of these had been carried out in the last year.

The practice participated in local benchmarking run by the Clinical Commissioning Group (CCG). This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes that were comparable to other services in the area. For example, analgesic and bronchodilator medicines prescribing were amongst the lowest in the CCG area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with attending mandatory courses such as annual basic life support. We noted a good skill mix among the doctors with two number having additional diplomas in sexual and reproductive medicine, and one with diplomas in children's health and obstetrics. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

We saw that the nursing team met regularly and held nurses meetings to discuss patient needs, clinical performance and best practice. The nurse practitioner

carried out daily 'catch up' meetings with other nursing staff to check on their wellbeing as well as share practice and patient information. All nursing staff spoke positively about the team working culture within the team.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses, for example, a diploma in diabetes care and management.

The nurses had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, for the administration of vaccines, cervical cytology and holiday vaccinations. Those with extended roles for example, seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles.

Staff files we reviewed showed that where poor performance had been identified appropriate action had been taken to manage this.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. They received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from these communications. Out-of hour's reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within five days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Emergency hospital admission rates for the practice were relatively low at 11.5% compared to the national average of 13.6%. The practice was commissioned for the unplanned admissions enhanced service and had a process in place to follow up patients discharged from hospital. (Enhanced services require an enhanced level of service provision above what is normally required under the core GP contract). We saw that their protocol for actioning hospital communications was working well in this respect.

The practice held multidisciplinary team meetings quarterly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and the palliative care nurses and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

Several community services visited the practice, these included; a community matron; community nurses; a health visitor; a midwife; monthly visits from a dietician and referrals were made to counselling services provided by Somerset community 'Right Steps' service.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and had this fully operational. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future

reference. We saw evidence that audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found that the majority of staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling it. The majority of clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. However one clinician we spoke with did not have a full understanding of the Act. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes. However we noted that whilst codes existed on the patient records to indicate 'best interest' decisions had been made there was no template to record how the reason for the decision was reached. We saw decisions were recorded as having taken place however, details of how the decisions were reached was inconsistent.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, where minor surgical procedures took place, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years when they attended routine appointments and offering smoking cessation advice to smokers and referrals to 'Smoke Free Life Somerset' to those patients who wished to stop smoking.

The practice offered NHS Health Checks to all its patients aged 40 to 74 years. All patients in this age category were offered this service. We were shown the process for following up patients within two weeks or sooner if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support and it was pro-active in offering additional help. For example, the practice had identified the number of patients diagnosed with diabetes and who were overweight. They offered dietary and exercise advice to all of these patients. There was evidence these were having some success as there were currently no patients who were in the highest risk category (red) for diabetes.

Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. For example, the practice referred patients to the dietician for dietary advice. Additionally one of the nurses from the practice had initiated a swimming group for patients diagnosed with diabetes who were overweight and who were conscious of their body image.

Good

Are services effective?

(for example, treatment is effective)

The group was held in a private session at a nearby swimming pool. The group was currently supported by one of the patient participation group committee who stated it was popular and beneficial for those who attended it.

The practice's performance for the cervical screening programme was 81.5%, which was almost the same as the national average of 81.9%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test and other tests. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example:

- Flu vaccination rates for the over 65s were 77.4%, and at risk groups 64.4%. These were above the national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 90% to 92.3% and five year olds from 78.6% to 100%. We saw 100% was achieved for all but two of the immunisations in this category. These were above the CCG average.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the national patient survey published in January 2015, a report undertaken by the practice's patient participation group (PPG) dated March 2015 and recent friends and family questionnaire results. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

The evidence from all these sources showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated in the middle range for patients who rated the practice as good or very good. The practice was also about average for its satisfaction scores on consultations with GPs and nurses. For example:

- 88.3% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87.2%.
- 89.5% said the GP gave them enough time compared to the CCG average of 88.5% and national average of 85.3%.
- 93.3% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.8% and national average of 92.2%

There were similar averages for the nursing team in the practice.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 30 completed cards and the majority were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. Three comments were less positive but there were no common themes to these. We also spoke with ten patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was in a separate area which helped keep patient information private. Additionally, 81% said they found the receptionists at the practice helpful with 98% saying the last appointment they had was convenient for them.

Staff told us that if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected, they would raise these with the practice manager. The practice manager told us they would investigate these and any learning identified would be shared with staff.

There was a policy outlining the practice's zero tolerance for abusive behaviour, this information was also on the practices website. Receptionists told us that referring to this had helped them diffuse potentially difficult situations.

Patients whose circumstances may make them vulnerable and those experiencing poor mental health were able to access the practice without fear of stigma or prejudice. We saw staff treating people from these groups in a sensitive manner and training was available to staff about how to deal sympathetically with all groups of people through online equality and diversity courses.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 87.5% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85.6% and national average of 82%.
- 82% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78.4% and national average of 74.6%.

Good

Are services caring?

The data for nurses was similarly positive in the above areas.

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

Staff told us that translation services were available for patients who did not have English as a first language. We saw information on the practices website informing patients this service was available.

We saw care plans for the most vulnerable older patients and patient involvement in agreeing these; this included information about end of life planning and preferences. There were also care plans for the most vulnerable patients with long-term conditions and their involvement in agreeing these.

Patient/carer support to cope emotionally with care and treatment

The patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example:

- 84.9% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86.1% and national average of 82.7%.
- 84.8% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.8% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required. They also showed staff signposting patients to other methods of support through voluntary groups and self-referral counselling groups.

Notices in the patient waiting room and the practices website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them and saw how carers were put in touch with local support groups such as 'Compass Care'.

Staff told us that if families had suffered a bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service. Patients we spoke with who had had a bereavement confirmed they had received this type of support and said they had found it helpful.

We saw evidence the practice recognised isolation as a risk factor for older patients and those patients living in rural areas of the catchment area. The practice supported these patients through home visits, online services and providing information about other sources of support to address this. Patients with long-term conditions and multi-morbidities were also similarly supported.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example, through a range of appointments, clinics and referrals to consultants and other services and through gathering feedback from patients.

The NHS England Area Team and Somerset Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. We saw minutes of meetings where this had been discussed and actions agreed to implement service improvements to better meet the needs of its population. For example, by providing patient centred treatment.

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

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). These included, raising patient awareness of online prescriptions, increasing representation on the PPG and communicating with patients regarding the running time of surgeries. The most recent (2015) report from the PPG also reviewed the actions from previous reports to monitor improvements identified then.

The practice had recognised patients had needs for other services and arranged for private practitioners to visit the practice. We saw that a podiatrist visited the practice on Tuesday afternoons and a chiropractor visited each Thursday afternoon.

The practice was part of a locally based project, called the Symphony project, which was aiming to provide enhanced support to patients with three or more diagnosed conditions. (The Symphony Project intends to redesign the way in which patients with multiple needs are cared for; integrating primary care, acute care, social care, community services, mental health services, housing, education, voluntary sector and the local authorities). When fully implemented each patient would have a named key worker who would develop a 'My life plan' with the patient. Each patient would then be placed into a risk based banding which identified who were self-managing their conditions, who required more support via a care co-coordinator and who would need regular reviews and end of life support. Practice staff would receive additional training to help support patients involved in the scheme.

In support of local hospital based cancer services one of the patients knitted scarves which were sold by one of the practices staff. The money raised went to support the on-going running of the service which several of the practices patients had benefited from using.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with learning disabilities where required. The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed. The practices website also had translation facilities if required by patients. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients. A hearing loop was provided in the reception area to help patients using a hearing aid to hear clearly.

The premises and services had been designed to meet the needs of patients with disabilities. There were two designated disabled parking spaces in the car park and the practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities were provided when requested. There was a large waiting area with plenty of space for wheelchairs and pushchairs. This made movement around the practice easier and helped to maintain patients' independence.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Staff told us that they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records.

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

One of the practice GPs was a provider of food bank vouchers. Their involvement had come about in response to patient consultations which identified stress related illnesses or issues linked to individual financial concerns. To assist in alleviating the stresses the GP had found out how to support patients through the voucher scheme and had become a voucher holder. A small number of patients were now being supported through this support.

The practice provided equality and diversity training through e-learning and training courses. Staff we spoke with confirmed that they had completed or were about to attend the equality and diversity training and that equality and diversity was regularly discussed at staff appraisals and team events.

For patients who may be living in vulnerable circumstances there was a system for flagging vulnerability in individual records. Patients were easily able to register with the practice, including those with "no fixed abode" care of the practice's address. People not registered at the practice were able to access appointments through the emergency appointments available.

Access to the service

The practice was open from 8am to 6:30pm Monday to Friday. GP appointments were available from 9am to 6pm on most weekdays. The practice operates an emergency only service between 8:00am – 8:30am, 12:30pm – 2:00 pm and 6:00 – 6:30pm. There were also nurse led clinics during normal surgery hours; additionally they also provided a phlebotomy service from 8:30am by appointment. Extended opening times were available between 6:30pm and 9:15pm for patients who were unable to get to the practice during normal hours every third Wednesday evening. The practice was also open two Saturday mornings between 8:45am and 11:45am. Online appointment access and repeat prescription ordering was also available. The practice was planning to increase its online appointment booking in July 2015 to include the first three appointments for all GP sessions. We were told by the two GPs we spoke with how they added extra appointments to their sessions if they were in a period of high demand to ensure all urgent needs were met.

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

Longer appointments were also available for older patients, those experiencing poor mental health, patients with learning disabilities and those with long-term conditions. This also included appointments with a named GP or nurse. Home visits were made to three local nursing and care homes; the nursing home was visited on a specific day each week, by a named GP. Home visits were also made to those patients who needed one.

The patient survey information we reviewed showed patients responded positively to questions about access to appointments and generally rated the practice well in these areas. For example:

- 82.2% were satisfied with the practice's opening hours compared to the CCG average of 77.1% and national average of 73.8%.
- 90.3% described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 79.9% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 93.1% said they could get through easily to the surgery by phone compared to the CCG average of 76.8% and national average of 71.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that they could see a GP on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another GP if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice. For example, within two hours of contacting the practice where a child had become unwell overnight.

Appointments were available outside of school hours and the premises were suitable for children and young people. Young person's appointments were available with the nurse practitioner where young patients could discuss contraception and receive sexual heath advice and information in confidence. The practice had signed up to provide free condoms through the national 'C' card scheme and there was anecdotal evidence to indicate this helped reduce unplanned teenage pregnancy.

An online booking system which benefitted the working population was available and easy to use as well as telephone consultations where appropriate. The practice supported patients to return to work through the fit note scheme. (A fit note allows GPs and other healthcare professionals to give patients more information about how a patient's condition affects their ability to work. This will help employers understand how they might help the patient return to work sooner or stay in work).

The practice had a 'carer's champion' and they had identified about 100 patients with a caring role. They provided information, advice and referrals to local support groups such as Compass Care to enable carers to maintain their caring role. GPs offered carers longer appointments to enable them to discuss their emotional support as well as health needs.

The nurse practitioner was supported by the practice (in a voluntary role for the West Somerset Railway) to carrying out nurses assessments of volunteers at the railway. They had also given a health talk to the local over 55 club and ran a health education stall in conjunction with the patient participation group at the local fete for the last two years.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. A GP and the practice manager were designated as responsible persons for handling all complaints in the practice.

We saw that information was available to help patients understand the complaints system for example, information about how to complain was displayed in a leaflet in the waiting area and on the practices website. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice.

We looked at four complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. The practice had a policy of openness and transparency when dealing with the complaints and kept patients informed of what they were doing in response to the complaint made. We saw the practice told the patient about the outcome of their investigations and apologised to patients in writing where this was appropriate.

The practice reviewed complaints annually to detect themes or trends. We looked at the report for the last review and no themes had been identified. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. Minutes of team meetings showing that complaints were discussed to ensure all staff were able to learn and contribute to determining any improvement action that might be required.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and current business plan (2015). We saw evidence the strategy and business plan were regularly reviewed by the practice and also saw the practice values were clearly displayed in the waiting areas and in the staff room. The practice vision and values included; putting our patients first; working with patients and working together. We saw these values were made available to patients on the practices website.

All the members of staff we spoke with knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the practice meetings and saw that staff had discussed and agreed that the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at nine of these policies and staff confirmed that they had read the policies and referred to them when required or needed. All nine policies and procedures we looked at had been reviewed annually and were up to date.

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

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. The included using the Somerset Practice Quality Scheme (SPQS) and Quality and Outcomes Framework to measure its performance (QOF is a voluntary incentive scheme which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures). The data for this practice showed it was performing in line with national standards. We saw that performance data was regularly discussed at clinical meetings and action plans were produced to maintain or improve patient outcomes.

The practice also had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, where medicines required reviewing, where building maintenance was required and where policies required updating. Evidence from other sources, including incidents and complaints was used to identify areas where improvements could be made. Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. They had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example, improving fire safety, carrying out patient reviews and enhancing security. The practice monitored risks on a monthly basis to identify any areas that needed addressing.

The practice held monthly staff meetings and clinical meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

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

Leadership, openness and transparency

The partners in the practice were visible in the practice and staff told us that they were approachable and always took the time to listen to all members of staff. All staff were

Are services well-led?

Good

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

involved in discussions about how to run the practice and how to develop the practice: the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

We saw from minutes that team meetings were held monthly. Staff told us that there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and confident in doing so and felt supported if they did. We also noted that team away days were held every 12 months. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

The practice employed named locum GPs to cover absences such as holidays, this enabled continuity of patient care. The locum GP we spoke with spoke positively about the leadership and communication from the practice and about the teamwork and enthusiasm from all staff. They told us there were clear patient notes which enabled them to provide continuity of patient care with the patient at the heart of the appointment.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through the patient participation group (PPG), surveys and complaints received. They had an active PPG which included representatives from various population groups such as those who were recently retired and patients with long term conditions. The PPG had carried out annual surveys and met every two months and more often if needed. The practice manager showed us the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys are available on the practice website. We spoke with two members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care). The practice did not currently have a patient suggestion box in the waiting area to gather feedback as it had been damaged by a patient. There was a feedback form on the practices website. The practice manager arranged for the suggestion box to be replaced during our inspection.

We also saw evidence that the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients. When appraisals were being undertaken the practice had adopted a 360 degree appraisal approach. This allowed staff from all levels to contribute to the appraisal and provide feedback on the performance of staff.

Management lead through learning and improvement

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

The practice had completed reviews of significant events and other incidents and shared with staff at meetings and away days to ensure the practice improved outcomes for patients. For example, improved prescription provision and security, improved communication with hospital consultants and raised awareness of childhood diseases.

The management and staff team had lead responsibility for both clinical and non-clinical aspects of the management of the practice. These roles were clearly defined and staff were aware of who was responsible for each area. The majority of these roles also had another member of staff to act as added support to ensure a wider sharing of information; administration support was also provided to some roles such as, clinical indicators and health and safety.