Doctors Hart, Taylor and Huins

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Doctors Hart, Taylor and Huins (Queen Camel Medical Centre) on 22 September 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing caring, well-led, effective, safe and responsive services. It was also good for providing services for the Older patients, Patients with long-term conditions, Families, children and young patients, Working age patients (including those recently retired and students), Patients whose circumstances may make them vulnerable, and patients experiencing poor mental health (including patients diagnosed with dementia).

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed, including those relating to recruitment checks.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with a high degree of compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand. We saw the practice had received a wealth of positive comments from patients and these were reflected in the comments of patients we spoke with.
- Patients said they found it easy to make an appointment, these could be made with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.

Summary of findings

- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

We noted areas of outstanding practice:

- The practice had a truly holistic approach to assessing, planning and delivering care and treatment and provided outstanding elements of support for patients particularly for patients nearing the end of their life, those who had a recent bereavement and for their carers. Patients in the end stages of their illness were cared for exclusively by their regular GP. The family had access to the home phone number of the relevant GP at this time who provided 24 hour care and support. More than twice the national average number of patients were able to die at home (their chosen location) through care and support provided by the practice.
- There was a proactive approach to understanding the needs of different groups of patients. The practice had a text service for teenage patients allowing them priority access to appointments via text messages to the practice. The service was provided in response to teenage patients saying it was their preferred method of communication. Practice GPs provided a weekly clinic during term time at a local preparatory school with 120 boarders.
- Feedback from patients who used the service was continually positive about the way staff treated them. Patients provided many examples of the caring nature of practice staff. GPs gave them personal phone numbers, visited them in the evenings and at weekends during times of difficulty or bereavement and give additional personal time to talk with family members about medical diagnosis.

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

Importantly the provider should;

- Review procedures for medicines taken to other collection points, to ensure a robust audit trail is maintained.
- Review the fire evacuation procedure to make clearer the roles, responsibilities and procedures for staff and patients.
- Review complaints processes to ensure a clearer record of complaints is maintained and records are retained for the required period.

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 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 patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

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

Summary of findings

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

Are services well-led?

Good

The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient 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 patients with some outstanding elements of support for patients nearing the end of their life. Nationally reported data showed outcomes for patients were good for conditions commonly found in older patients. The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in dementia and end of life care. Some of these aspects of care were outstanding, particularly for the care of patients nearing the end of their life. The practice was responsive to the needs of older patients, 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 patients 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 their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young patients. 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 patients who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Patients told us children and young patients were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. The practice had an outstanding element of care for teenage patients and provided a dedicated text appointment service for these patients. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (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 patients whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances those with a learning disability. It had carried out annual health checks for patients with a learning disability and 100% of these patients had received a follow-up appointment. It offered longer appointments for patients with a learning disability and for those patients who required more time to discuss their problems. The practice provided outstanding elements of care for patients. Patients provided many examples of the caring nature of practice staff. GPs gave them personal phone numbers, visited them in the evenings and at weekends during times of difficulty or bereavement and give additional personal time to talk with family members about medical diagnosis.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. 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 patients experiencing poor mental health (including patients 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 patients experiencing poor mental health, including those with dementia. It carried out care planning for patients with dementia. Where patients were

experiencing emotional problems or who had experienced a recent bereavement we heard how the GPs, nurses and other staff supported them through home visits, referrals to other services and stopping for a chat informally outside of their work.

The practice had told patients 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. Staff had received training about how to care for patients with mental health needs and dementia. The practice had joined the national dementia friends' initiative with all staff aware of the needs of patients diagnosed with dementia.

Summary of findings

What people who use the service say

We spoke with 18 patients visiting the practice including three members of the patient participation group during our inspection. We received 14 comment cards from patients who visited the practice and saw the results of the last patient participation group survey. Feedback from patients who used the service, those who are close to them and stakeholders were continually positive about the way staff treat patients. Patients told us staff, 'go the extra mile' and the care and support they received exceeded their expectations.

The practice shared their findings from their current 'friends and family' survey. We looked at the practices 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 looked at data provided in the most recent NHS GP patient survey (January 2015) and the Care Quality Commission's information management report about the practice.

Without exception comments made or written by patients were highly positive and praised the care and treatment they received and the helpful nature of all staff in the practice. Comments included; receiving prompt treatment at all times, about appointments being at times convenient to patients, being able to see a named GP where a preference was stated and about being involved in decisions about the best treatment for their diagnosis.

From the interviews we carried out and our observations during the day we saw patients always found access to the practice and appointments easy and saw how telephones were answered after a brief wait. The most recent GP survey showed 100% of patients found it easy to get through to the practice by telephone compared to a Clinical Commissioning Group average of 78.6%.

Patients told us they used the practices online booking systems to arrange or cancel appointments and to request repeat prescriptions or update their personal details.

Patients told us the practice was always kept clean and tidy and periodically it was refurbished and improved facilities added. They told us during intimate examinations GPs and nurses wore protective clothing such as gloves and aprons and examination couches were covered with paper protective sheets. 99.5% of patients describe their overall experience of this practice as good.

We saw a range of thank you cards and comments sent to GPs and nurses in the practice. These all thanked staff for their caring approach and their support at times of emotional need and ill health.

Patients told us their privacy and dignity was respected during consultations and they found the reception area was sufficiently private for most discussions they needed to make. Patients told us about GPs supporting them at times of bereavement and providing extra support to young carers. A large number of patients had been attending the practice for many years and told us about how the practice had grown but they were always treated well. The GP survey showed 100% of patients said they had confidence and trust in the last GP they saw or spoke with, a similar figure of 99.4% was recorded for the nurses they saw.

Patients commented on the openness, accessibility and leadership of the practice, particularly the partner GPs. Patient participation group members told us the partners and management staff engaged with them and encouraged their participation in decisions about improving the practice. They told us comments were listened to and improvements were made to the services provided and the environment they were provided in.

Areas for improvement

Action the service SHOULD take to improve
Action the provider SHOULD take to improve:

There were areas of practice where the provider could make improvements.

Summary of findings

Importantly the provider should;

- Review procedures for medicines taken to other collection points, to ensure a robust audit trail is maintained.
- Review the fire evacuation procedure to make clearer the roles, responsibilities and procedures for staff and patients.
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Outstanding practice

We noted areas of outstanding practice:

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Doctors Hart, Taylor and Huins

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 and a variety of specialists including a practice manager, a practice nurse and a pharmacist. We were accompanied by an Expert by Experience. Experts by Experience are a part of the inspection team and help with patient interviews; they are granted the same authority to enter registered persons' premises as the CQC inspectors.

Background to Doctors Hart, Taylor and Huins

Queen Camel Medical Centre is located a short distance from the centre of the village of Queen Camel and about seven miles from Yeovil, Somerset. The premises were purpose built in 2003 with parking on site and level access into the building. The practice has approximately 5500 registered patients. The practice area extends to a 6.5 mile radius surrounding the practice and includes communities such as Galhampton, North and South Cadbury, Lydford, Marston Magna, Sandford Orcas and Mudford. The practice works within Somerset Clinical Commissioning Group (CCG), which is responsible for the provision of health care throughout Somerset. The practice provides surgeries in village halls at North Cadbury and Galhampton on Tuesday and Thursday afternoons.

There are four GPs and a team of clinical staff including two practice nurses, two phlebotomists and five dispensary staff. One GP is female and three are male, the hours contracted by GPs are equal to 3.34 whole time equivalent employees. Collectively the GPs provide 28 clinical patient sessions each week in addition they provide extended hours for patients. Additionally the nurses employed equal to 0.83 whole time equivalent employees. Non-clinical staff include secretaries, receptionist staff and a practice manager. The practice was a teaching practice and supported one registrar GP at the time of our inspection.

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. There are about 0.4% of patients from non-white 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 99.2% of patients said they would recommend the practice to someone new to the area. This was significantly above the Clinical Commissioning Group average of 82.5%. Local Public Health statistics (January 2014) demonstrate Queen Camel Medical Centre population area had income deprivation levels for children and older patients below to the national average; 10 and 12.1 compared to 22.5 and 23.6 respectively.

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 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.

The practice has opted out of providing out-of-hours services to their own patients. This service is provided by Vocare (Northern Doctors Urgent Care) 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 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 22 September 2015.

We talked with the majority of staff employed in the practice who were working on the day of our inspection. This included three GPs, a registrar GP, a practice nurse, the practice manager and four administrative and reception staff. We spoke with three members of the patient participation group, 18 patients and received Care Quality Commission comment cards from a further 14 patients.

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 a medicines refrigerator stopped working and immediate action was required to ensure medicines stored in the fridge remained safe to use.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the previous 18 months. These showed the practice had managed these consistently over time and could show evidence of a safe track record over the long term.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of eight significant events which had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and a dedicated meeting was held quarterly to review actions from past significant events and complaints. There was evidence the practice had learned from these and 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 four incidents and saw records were completed in a timely manner. We saw evidence of action taken as a result and the learning had been shared for example, providing a new paper scanning protocol and entering the correct test title onto patient records. Where patients had been affected by something which 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 the practice manager where appropriate to 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 told us alerts were discussed at staff meetings as well as at informal coffee break meetings. These ensured all staff were aware of any alerts which 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 patients and adults. We looked at training records which showed staff had received relevant role specific training about safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff described how they would recognise signs of abuse in older patients, vulnerable adults and children. They were 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 in policy documents.

The practice had appointed dedicated GPs 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 these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the electronic patient record system. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. 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 available in the waiting room 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. 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).

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely. They were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Where a refrigerator failure had occurred we saw the policy had been followed and appropriate action had taken place. Records showed fridge temperature checks were carried out 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

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines had been produced in line with legal requirements and national guidance. We saw sets of PGDs had been updated over the course of the year. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) had been produced by the prescriber. We saw evidence 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 PSD from the prescriber.

We checked how medicines were stored in the dispensary and found they were stored securely and were only accessible to authorised staff. Records showed medicines needing refrigeration were monitored and temperature checks were carried out which ensured medicines requiring cold storage were stored at the appropriate temperature. We noted there were no records of room temperature monitoring kept to ensure other medicines were stored at suitable temperatures. Systems were in place to check medicines were within their expiry date and suitable for use. 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. Prescription forms in the dispensary were stored securely and an audit trail of the handling of these forms within the practice was maintained in line with national guidance.

The practice had established collection points for some patients to obtain their medicines from more convenient locations. From our discussions with dispensary staff we noted there were no formal systems in place to monitor how these medicines were collected. There had been no incidents where patients had not received their medicines. There were arrangements in place to ensure patients were given all the relevant information they required.

The practice held stocks of controlled drugs (medicines which require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures setting out how they were managed. These were being followed by the dispensing staff. For example, controlled drugs were stored in a controlled drugs cupboard, access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice had appropriate procedures in place for the production of prescriptions and dispensing of medicines which were regularly reviewed and accurately reflected current practice. Medicines packaging were scanned using a barcode system to help reduce the likelihood of any dispensing errors.

Good

Are services safe?

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.

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 minor surgery procedures. There was a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a member of staff 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. We saw evidence the lead had carried out audits and any improvements identified for action were completed on time. Minutes of practice meetings showed the findings of the audits were discussed.

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.

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 that confirmed the practice was carrying out regular 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 all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was within the last two years. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example, weighing scales, spirometers, blood pressure measuring devices and the fridge thermometers.

Staffing and recruitment

The practice had a recruitment policy setting out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence to demonstrate 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 enough staff were on duty. There was an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave.

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate 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. We noted an electrical wiring check had not been carried out since the premises were built and highlighted this to the practice manager. The practice 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.

Good

Are services safe?

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 service and staffing changes (both planned and unplanned) were required to be included on the log. Meeting minutes we reviewed showed risks were discussed at practice closure meetings and within team meetings.

Staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. There were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly. The practice monitored repeat prescribing for patients receiving medicines for mental ill-health as well as for patients diagnosed with long-term conditions.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed all staff had received training in basic life support between April and September 2015. Emergency equipment was 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 it was checked regularly. We checked the pads for the automated external defibrillator were within their expiry date.

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 in place to check whether emergency medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use.

A business continuity plan was in place to deal with a range of emergencies which could 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 contained relevant contact details for staff to refer to. For example, contact details of a utility company for circumstances where the heating, lighting or water supply systems failed.

The practice had carried out a fire risk assessment in 2015 which included actions required to maintain fire safety. Records showed that staff were up to date with fire training and they practised regular fire drills. However we noted the fire evacuation procedure lacked detail for example, about the role of fire wardens and accounting for staff, patients and visitors in the practice.

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, accessed guidelines from the National Institute for Health and Care Excellence (NICE) and guidance from local commissioners. We discussed with the practice manager, GPs and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. We saw minutes of clinical meetings which showed this was 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 and local guidelines.

Staff described how they carried out comprehensive assessments of patients which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, patients with diabetes and long term illnesses received regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required and this happened promptly. The practice provided a range of 'in house' diagnostic services for patients for example, electrocardiogram (to assess the electrical and muscular functions of the heart), spirometry (to help diagnose various lung conditions) and international normalised ratio (to monitor patients being treated with the blood-thinning medicines). These tests helped reduce the need for patients to travel to other services or hospitals to have their conditions monitored.

The GPs told us they had lead responsibility for specialist clinical areas such as women's health, cardiovascular medicine, mental health and diabetes. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Being a teaching practice clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines for example, for the management of dermatological conditions. Our review of the meeting minutes confirmed 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 their needs were being met to assist in reducing the need for them to go into hospital. We saw where patients were discharged from hospital they were followed up through phone calls and appointments to ensure all their needs were continuing to be met.

Discrimination was avoided when making care and treatment decisions. Interviews with GPs showed 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 patient care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager to support the practice to carry out clinical audits and local benchmarking.

The practice showed us clinical audits which had been undertaken in the last two years. Seven of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, a splenectomy (a surgical procedure to remove the spleen) and vaccination audit which resulted in a letter being sent to all patients who had a splenectomy advising then of the need for further vaccinations. Other examples included audits, vaccine storage, dispensing audit, hormone replacement therapy review and an audit of deaths in the practice over a two year period.

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). (QOF is a voluntary incentive scheme for

Good

Are services effective?

(for example, treatment is effective)

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). For example, we saw an audit regarding patients being prescribed hormone replacement therapy (HRT). Following the audit, the GPs carried out medicines reviews for patients who were prescribed these therapies and reviewed 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 used the information collected for the QOF 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 75% of the total QOF target in 2013/14, which was below the national average of 94.2%. Specific examples to demonstrate this included:

- Performance for diabetes related indicators was slightly below the national average.
- The percentage of patients with hypertension having regular blood pressure tests was below the national average
- Performance for mental health related and hypertension QOF indicators were below the national average.
- The dementia diagnosis rate was above the national average

The practice was aware of all the areas where performance was not in line with national or CCG figures as they had not participated in QOF during this period due to their involvement in the Somerset Practice Quality Scheme. However we saw action plans and practice data setting out how these were being addressed. Prior to not participating in QOF the practice annual return was 99.5%, amongst the best in the area.

The team was making use of clinical audit tools, clinical supervision, informal discussions 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 there was an expectation all clinical staff should undertake audits annually.

Data from the 2013 to 2014 QOF showed the practice's prescribing rates were similar to national figures. More recent figures provided in a report from the Clinical Commissioning Group's (CCG) pharmacist showed the practice had improved prescribing rates considerably and was amongst the lowest prescribers of antibacterial prescribers in the CCG. There was a protocol for repeat prescribing which followed national guidance. They checked all routine health checks were completed for long-term conditions such as diabetes and 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. It 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. The patients we spoke with praised the practice staff highly for their support where end of life care and treatment was required. We heard from patients and staff how patients in the end of life phase of their illness were invariably cared for exclusively by their regular GP. The family had access to the home phone number of the relevant GP at this time who provided 24 hour care and support.

The practice kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups; such as those with mental health needs and elderly patients living in isolation. Structured annual reviews were undertaken for patients with long term conditions for example, those diagnosed with diabetes, chronic obstructive pulmonary disease or heart failure. We were shown information which indicated most of these had been carried out in the last year.

The practice participated in local benchmarking run by the 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 comparable to other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and

Good

Are services effective?

(for example, treatment is effective)

saw all staff were up to date with attending courses such as annual basic life support. We noted a good skill mix among the doctors with one having additional diplomas in sexual and reproductive medicine, and four 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 noted the practices training log did not record the date of the last time the staff updated some aspects of their learning for example, fire drills and chaperone training.

All staff undertook annual appraisals which identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example, a diploma in diabetes care and management. As the practice was a training practice, doctors who were training to be qualified as a GP were offered extended appointments and had access to a senior GP throughout the day for support. We received highly positive feedback from the trainee we spoke with and noted a former trainee was due to become a partner at the practice in October 2015.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence they were trained appropriately to fulfil these duties. For example, the administration of vaccines, cervical cytology and phlebotomy (taking blood samples). Those with extended roles such as seeing patients with long-term conditions for example, asthma, chronic obstructive pulmonary disease (COPD), diabetes and coronary heart disease were able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

Emergency hospital admission rates for the practice were positively low at 9.74% compared to the national average of 14.4%. 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 the policy for actioning hospital communications was working well in this respect and this was confirmed by the patients we spoke with. The practice undertook regular audits of follow-up appointments to ensure they were not inappropriate or missed.

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 Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received.

Hospital discharge summaries and letters from outpatient appointments 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.

The practice held multidisciplinary team meetings monthly to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, patients from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses, palliative care nurses, the local authority (if needed) 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.

The practice is participating in all relevant South Somerset Federation meetings; in addition they were a founder member of the rural practices network for the area which met monthly. They engaged with the Symphony project in South Somerset; they are also involved in, and supportive of, the Yeovil Vanguard project (as part of the second wave pilot). The project is a partnership between Yeovil District Hospital NHS Foundation Trust, Somerset Clinical

Good

Are services effective?

(for example, treatment is effective)

Commissioning Group, South Somerset Healthcare GP Federation and Somerset County Council which will be working to deliver an Integrated primary and acute care system.

Information sharing

The practice used 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. Patients we spoke with confirmed they had these plans. The practice had 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 in the use of 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 audits had been carried out to assess the completeness of these records and action had been taken to address any shortcomings identified.

Consent to care and treatment

Staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it.

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. Templates were available on the patient record system to help clinicians consistently record their decision making process. 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 protocol for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. 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; the 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.

The practice offered 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 and offering smoking cessation advice to smokers.

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 smoking status of patients over the age of 16, patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs.

The practice's performance for the cervical screening programme was 84.44%, which was above the national average of 81.88%. There was a process to offer telephone

Good

Are services effective?

(for example, treatment is effective)

reminders for patients who did not attend for their cervical screening test. The practice encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

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

- Flu vaccination rates for the over 65s were 72.3%, and at risk groups 50.45%. These were similar to national averages.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 93.5% to 100% and five year olds from 95.3% to 97.7%. These were comparable to national averages.

One of the GPs produced a regular newsletter for inclusion into the local parish magazine. The articles promoted patient health care and raised awareness of upcoming services such as flu and shingles vaccination sessions. The articles explained about changes in registrar GPs and accessing the practices services. Patients who had read these articles told us they found them helpful.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction; the results we saw were exceptionally positive. These included information from the national patient survey January 2015, a survey of patients undertaken by the practice's patient participation group (PPG) dated March 2015 (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care) and Friends and Families questionnaire information made available by the practice.

The evidence from all these sources showed patients were very satisfied with how they were treated and this was with compassion, dignity and respect. For example, data from the national patient survey showed the practice was rated 'among the best' for patients who rated the practice as good or very good. The practice was above average for its satisfaction scores on consultations with doctors and nurses. For example:

- 97.9% of patients said the GP was good at listening to them compared to the CCG average of 91.6% of patients and national average of 88.6%.
- 96.5% of patients said the GP gave them enough time compared to the CCG average of 89.8% and national average of 86.8%.
- 100% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95.3%
- 99.4% of patients said they had confidence and trust in the last nurse they saw compared to the CCG average of 98.3% and national average of 97.2%

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 14 completed cards all were highly positive about the services experienced. Patients said they felt the practice offered a better than excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We spoke with 18 patients on the day of our inspection. All told us they were very satisfied with the compassionate care provided by the practice and said their dignity and privacy was respected at all times.

Staff and patients told us all consultations and treatments were carried out in the privacy of a consulting room.

Disposable curtains were provided in treatment rooms so patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted consultation and treatment room doors were closed during consultations and conversations taking place in these rooms could not be overheard.

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. Patients responding to the last National GP patient survey were complementary about the reception team; 93.9% said they found the receptionists at the practice helpful compared to the CCG average of 89% and national average of 86.9%.

Staff told us 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.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients responded very 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:

- 98.4% of patients said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90.1% and national average of 86.3%.
- 94.4% of patients said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86.1% and national average of 81.5%.

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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. We heard many stories of how GPs 'went the extra mile' to support patients. For example, by giving them personal phone numbers, visiting them in the evenings and at weekends during times

of difficulty or bereavement and giving additional personal time to talk with family members about medical diagnosis. Patient feedback on the comment cards we received was highly positive and aligned with these views.

We saw evidence of care plans for older patients and patient involvement in agreeing these. We heard from carers of patients we spoke with how they were provided with summary care plans where the cared for person might be at risk of needing an urgent hospital admission. Where relevant the care plans included information about end of life planning and were signed by patients or their carers. Where end of life discussions took place the GPs asked patients about their preferred place to die and worked with them to achieve their preferred choice. Most patients chose a setting most familiar to themselves. Information provided by the practice showed almost 60% of expected patient deaths took place at home compared to 23% nationally.

We saw families, children and young patients were treated in an age-appropriate way and children were recognised as individuals with their preferences considered. We observed nurses greeting children directly and by their chosen name. Expectant mothers we spoke with talked about how maternity care was 'joined up' in the practice with GPs and nurses liaising with community midwives based in the practice to share patient information. Mothers with young children told us about the caring way vaccinations were provided to their children and how their healthcare was monitored. The practice had a dedicated text service for teenage patients allowing them priority access to appointments via text messages to the practice. The service was provided in response to teenage patients saying it was their preferred method of communication. We saw how reception staff monitored the mobile phone throughout the day for messages and how appointment requests were made accordingly.

Patient/carer support to cope emotionally with care and treatment

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

- 97.6% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 88.9% and national average of 85.1%.
- 94.5% of patients said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 90.4%.

The patients we spoke with on the day of our inspection and the comment cards we received were consistent with this survey information. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website 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.

Staff told us if families had suffered bereavements 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 experienced bereavements confirmed they had received this type of support and said they had found it helpful.

The practice had a register of carers; each carer had a 'read code' in their notes. There was an identified carers champion; they attended additional training sessions and liaised with local carer groups. The waiting room TV advertised the champion as well as any relevant events. The practice website provided a range of information for carers. The practice referred to and liaised with Compass Carers, a local information and support group for carers in Somerset, to ensure carers received support enabling them to maintain their caring role.

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, ensuring sufficient skilled staff were employed each day, providing a range of appointments throughout the week and listening to what patients said about the services via the patient participation group.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements which 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, outsourcing smoking cessation clinics and the provision of health checks in line with CCG guidance.

The practice 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 implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG). For example, changing the blood pressure self-monitoring equipment to a simpler machine and initiating a carers register.

The practice had looked at ways of ensuring patients who needed less frequent follow-up appointments did not miss out. For example, those who need DEXA scans (a type of X-ray that measures bone mineral density), abdominal aortic aneurysm scans and other tests and investigations which were often done annually or less frequently. In these cases patients were coded in a clinical system to allow searches to be carried out. The practice carried out a monthly search for such patients and reminded them of the need to plan their next investigation or test.

We heard how GPs provided a weekly clinic during term time at a local preparatory school with 120 boarders. This supported the schools permanent nurse who delivered basic healthcare to the students. A GP we spoke with told us about how they responded to patients' needs. An example they described showed how a patient who had a "funny turn" was referred to a rapid access transient ischaemic attack (TIA) clinic. There were concerns about whether the patient could drive safely. Driving is important for working age patients in this part Somerset. A prompt appointment was gained and tests carried out enabling the patient to continue driving and maintain their employment.

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 diagnosed with dementia and for those with a learning disability. The majority of the practice population were English speaking patients. If needed access to online and telephone translation services were available if needed. Staff were aware of when a patient may require an advocate to support them and there was information on advocacy services available for patients.

The premises and services had been designed to meet the needs of patients with disabilities. The practice was accessible to patients with mobility difficulties as most facilities were all on one level. There was a lift to the first floor of the practice. The consulting rooms were accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a large waiting area with space for wheelchairs and pushchairs, we noted access to part of the waiting room was restricted for wheelchair users and brought this to the attention of staff.

There was a system for flagging vulnerability in individual patient records. Male and female GPs were available in the practice; therefore patients could choose to see a male or female doctor.

The practice provided equality and diversity training through e-learning. Staff we spoke with confirmed they had completed the equality and diversity training in the last 12 months and equality and diversity was regularly discussed at staff appraisals and team events.

Access to the service

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice was open from 08:30am to 6:30pm Monday to Friday with an emergencies only telephone service available from 8:00am each weekday. Appointments were available from 8:30am am to 11:30am on Saturdays for bookable appointments. Appointments in hours were bookable online, in person or by telephone. There were no restrictions on advanced appointment booking. A small number of appointments are reserved for on the day booking only; these were available through the reception team. Patients requesting appointments before 1:00pm were accommodated either face-to-face or by a telephone consultation if the patient preferred. After 1:00pm were offered a same evening appointment or next morning appointment.

The practice provided afternoon surgeries in village halls at North Cadbury and Galhampton on Tuesday and Thursday afternoons. These were mainly for older patients and for those who did not have transport to get to the practice in Queen Camel. We did not visit these afternoon sessions.

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 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. Patients we spoke with told us, without exception, access to the practice and appointments was easy. Information from the National patient survey corroborated this with 100% of patients saying they could get through to the practice easily by phone.

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

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

- 89.5% of patients were satisfied with the practice's opening hours compared to the CCG average of 77.2% and national average of 75.7%.
- 97.7% of patients described their experience of making an appointment as good compared to the CCG average of 79.2% and national average of 73.8%.
- 79.7% of patients said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70.1% and national average of 65.2%. All patients we spoke with said they understood the reasons for the wait and felt it was mainly due to the GPs listening to patients concerns.
- 100% of patients said they could get through easily to the practice by phone compared to the CCG average of 78.6% and national average of 74.4%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Comments received from patients showed those in urgent need of treatment were able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns as part of their significant events process. Its complaints policy and procedures were brief, this was recognised by the practice and they were in the process of reviewing the documents. The key points of the policy were in the practices patients complaints leaflet. The practice manager responded either in writing or by telephone within seven working days and if investigations took longer the patient was informed. The complaints leaflet detailed the current procedures for taking the complaint further if they were dissatisfied with the practices response.

There was a designated responsible person who handled all complaints in the practice. However, whilst we were provided with recent complaint records the practice had not retained evidence of complaints and how they were handled for the required 10 year period indicated in the governments Records Management retention scheduling 7 - Complaints records document.

Good

Are services responsive to people's needs?

(for example, to feedback?)

We saw information was available to help patients understand the complaints system in the patient leaflet and on the practices website. We noted the same document on the practice website referred to the "Primary Care Trust" and not the Clinical Commissioning Group and highlighted this to the practice who arranged to have it updated. Patients we spoke with were aware of how to make a complaint. None of the patients we spoke with had ever needed to make a complaint about the practice and only had praise for the services received.

We looked at two complaints received in the last 12 months and found these had been handled and dealt with in a timely way. We saw evidence of apology letters to the patients concerned and saw they were discussed at quarterly practice closure meetings as significant events to share learning from the events.

The practice reviewed complaints, including verbal complaints, to detect themes or trends. Lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result. Similarly the practice took the same approach to handling compliments; we were provided with evidence to show these were shared and discussed with staff.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. We found details of the vision and practice values were part of the practice's strategy and business plan. We saw evidence the strategy and business plan were reviewed by the practice. The practice vision and values included providing patient centred care and treatment, providing a high standard of medical care, ensuring safe and effective services and environment, maintaining a motivated and skilled staff team, monitoring and auditing to continually improve services and ensuring effective and robust information governance systems.

All members of staff we spoke with told us they knew and understood the vision and values and knew what their responsibilities were in relation to these and had been involved in developing them. We saw the practice had looked at how the vision and values could be sustained. We heard about management consultant input from an external organisation to look at planned partnership and practices changes and how new partners had been identified as part of the plan.

Governance arrangements

The practice had approximately 120 policies, procedures and processes in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at a small sample (14) of these policies and procedures. Staff we spoke with told us they had read the policies either when they took up their post or if they had been updated. The majority of the policies and procedures we looked at had been reviewed 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 most members of staff on duty during our inspection and they were all clear about their own roles and responsibilities. They all told us they felt highly 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 the systems in place to monitor the quality of the service were consistently being used and were effective. They included using the Somerset Practice Quality Scheme 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 QOF data for this practice showed it was performing in line with national standards. We saw data was regularly discussed at team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, patient recall appointments. Evidence from other data from 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 action had been taken, when appropriate, in response to feedback from patients or staff. The practice regularly submitted governance and performance data to the Clinical Commissioning Group.

The practice identified, recorded and managed risks. The practice monitored identified risks monthly to address any areas needing improvement. They carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example, in managing legionella in the water system, basic life support, vaccination cold chain management and premises security. However we noted some aspects of health and safety risk assessments such as electrical safety and display screen assessments were incomplete.

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found 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, recruitment procedures, management of sickness and annual leave which were in place to support staff. We were shown the staff handbook which 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 available to all staff electronically on any computer within the practice.

Are services well-led?

Good

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

Leadership, openness and transparency

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

There was a schedule of meetings which enabled staff to provide feedback about the service and to hear about service developments. There was a partners meeting with held jointly with the practice manager each Monday morning for an hour. There were whole practice meetings every three months which included sharing learning from significant events and complaints or concerns. The practice manager met with admin staff as required with occasional "virtual meetings" also being held. Notes of meetings were disseminated and made available for discussion at future meetings if required. The nursing team we spoke with told us they didn't have dedicated time for meetings with the phlebotomists (staff trained to take blood samples). They used the lunchtime break from patients to discuss key issues such as alerts and updated guidance and to share good practice with each other.

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

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 including; young patients, the working population, patients with long term conditions and older patients. The PPG had carried out annual surveys and met every two to three months.

The practice 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 three 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 practices 'Friends and Families' test results had shown over 99% of patients would recommend the practice.

The practice had promoted the use of their website as a way of information sharing and gaining feedback, as well as for patients to book appointments or request repeat prescriptions. Information provided by the practice showed patients were finding the practice useful with between 10 and 20,000 'hits' each month.

We saw evidence the practice had reviewed its' results from the national GP survey to see if there were any areas needing addressing. The results were amongst the very best in the Clinical Commissioning Group. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. As a result of discussions with the partners one of the nurses due to commence a diabetes diploma in October 2015. 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.

Management lead through learning and improvement

Staff told us the practice supported them to maintain their clinical professional development through training and mentoring. We looked at five staff files and saw appraisals took place which included a personal learning and development plan. Staff told us the practice was very supportive of training and they had practice closure sessions quarterly where additional learning took place.

The practice was a GP training practice and had a registrar GP located in the practice at the time of the inspection. One of the practices GPs was providing support to the registrar GP. The registrar told us they felt they received very good support from the leadership team and found it beneficial their GP trainer was also an examiner. They told us they were pleased to see patients had been able to book appointments with them both for acute and chronic conditions or complaints.

Are services well-led?

Good

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

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, improving their scanning protocol and ensuring telephoned lab results were passed to a GP promptly.