Millbrook Surgery - Castle Cary

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Millbrook Surgery - Castle Cary on 5 May 2016. Overall the practice is rated as good.

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

- There was an open and transparent approach to safety and a system in place for reporting and recording significant events.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, weekly meetings with the community psychiatric team and virtual patient clinics with specialist doctors and nurses.
- Risks to patients were assessed, mitigated and well managed.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with appointments available the same day.
- Information about services and how to complain was available and easy to understand. Improvements were made to the quality of care as a result of complaints, concerns, patient surveys and the patient participation group.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management and included within decision making processes to improve patient care. The practice proactively sought feedback from staff and patients, which it acted on.

Summary of findings

- The provider was aware of and complied with the requirements of the duty of candour.
- The practice had strong and visible clinical and managerial leadership and governance arrangements. For example, staff told us the partners were very accessible, listened to concerns and implemented change process to improve the quality of the service.
- The practice undertook pilot projects and was part of the NHS England vanguard, working to deliver an integrated primary and acute care system with health and social care providers.

We saw four areas of outstanding practice:

- The practice had listened to staff and patients around access to care and treatment. For example, the practice implemented an open access system which allowed patients to phone anytime on the day they required care and treatment, speak to a GP and if necessary see a GP of their choice on the same day. This meant patients did not have to wait for routine care and treatment. The practice could demonstrate the impact of this by positive patient survey results.
- There was a focus, by the practice, on continuous improvement of the quality of care and treatment provided. Which meant improved patient outcomes. For example, the employment of health coaches who offered support to patients and their families of any age who had recently been discharged from hospital, had a chronic condition, were vulnerable or isolated. Health coaches provided lifestyle advice, assistance with day to day tasks, access and referral to community services, support and care packages and personalised care plans for those at risk.
- Staff worked together as a team to understand and meet the range and complexity of patients' social and medical needs and to assess and plan ongoing care and treatment. For example, the practice held a staff led, twice weekly 'huddle' meeting for all staff. The meeting enabled any member of staff with a concern about or information about a patient to communicate it to the rest of the team and an action plan implemented. This meant the practice could be proactive and responsive to an individual patient's care and treatment.
- The practice had a clear focus on learning and continuous improvement. For example, effective responses to feedback from patients and staff; from reviews of audits and significant events; and proactive participation in local pilot schemes and close working with other organisations to plan how services were provided and to improve outcomes for patients.

The areas where the provider should make improvement are:

- The practice should compile a full list of staff immunity against infectious diseases.
- The practice should improve the completion of incidents reporting forms.

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.

- There was an effective system in place for reporting and recording significant events with a strategy in place to prevent reoccurrence. However we saw some inconsistencies in terms of significant events being documented within a central system although there was evidence each incident had been investigated fully and risks mitigated.
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse.
- Risks to patients were assessed and well managed.

Are services effective?

Good

The practice is rated as good for providing effective services.

- Data from the Somerset Practice Quality Scheme (SPQS), a local quality and outcomes framework showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- The practice operated a twice weekly 'Huddle' which was attended by all the practice staff and which discussed social and medical concerns of patients including those identified as vulnerable, isolated, at risk of admission or currently in hospital. The meeting was staff led with staff taking turns to chair the meeting.

Summary of findings

Are services caring?

Good

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- 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 saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they meet patients' needs. In 2015 the practice became a part of the south Somerset health community.This is a partnership of Yeovil District Hospital NHS Foundation Trust, Somerset Clinical Commissioning Group, South Somerset Healthcare GP Federation and Somerset County Council working to deliver an integrated primary and acute care system. It also involves patients, carers, and voluntary organisations.
- There are innovative approaches to providing integrated patient-centred care. For example, the introduction of health coaches and practice twice weekly 'huddle' meetings to look at patients medical and social vulnerabilities.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group. For example, the introduction of an open access appointment system where patients can speak to or see the GP of their choice when required. This meant patients can access appointments and services in a way and at a time that suits them.
- 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. We found that the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Summary of findings

Are services well-led?

Good

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

- The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff.
- High standards were promoted and owned by all practice staff and teams worked together across all roles.
- Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice.
- There was a high level of constructive engagement with staff and a high level of staff satisfaction.
- The practice gathered feedback from patients and had an engaged patient participation group which influenced practice development.
- There was a strong focus on continuous learning and improvement at all levels.
- The practice team was forward thinking and part of local pilot schemes and changes to practice processes to improve the quality of care and outcomes for patients.

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.

- The practice offered proactive, personalised care to meet the needs of the older people in its population.
- The practice was responsive to the needs of older people, and offered home visits and urgent appointments for those with enhanced needs.
- The practice provided additional services to enhance and empower patients. For example, patients at risk of a stroke were invited to a series of stroke prevention meetings.
- Health coaches actively identified older, isolated patients to sign-post and support them within a local network of community support groups.
- A twice weekly 'huddle' meeting identified patients at risk and allowed a proactive and responsive care and treatment plan for an individual patient.

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.
- The practice had organised a virtual clinic with specialist doctors and nurses to enable patients with diabetes to improve the management of their condition.
- 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. Chronic respiratory disease patients were seen six monthly. 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 people.

Summary of findings

- 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 children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this.
- The practices uptake for cervical screening was in line with local and national data.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- We saw positive examples of joint working with midwives, health visitors and school nurses.

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 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 who circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people and those with a learning disability.
- The practice offered longer appointments for patients who circumstances may make them vulnerable including those with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients.
- The practice informed vulnerable patients about how to access various support groups and voluntary organisations.

Summary of findings

- Health coaches offered support to patients and their families of any age. They provided lifestyle advice, assistance with day to day tasks, access and referral to community services, support and care packages and personalised care plans for those at risk.
- A twice weekly 'huddle' meeting identified patients at risk and allowed a proactive and responsive care and treatment plan for an individual patient.
- 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).

- Weekly ward rounds were held in a residential home for people with a diagnosis of dementia.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. For example, a weekly meeting took place with the community psychiatric nurse.
- The practice carried out personalised advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health. All these patients had received a telephone call from a health coach within three days of their admission.
- Staff had a good understanding of how to support patients with mental health needs and dementia. Staff had received dementia training.

Summary of findings

What people who use the service say

The national GP patient survey results were published in January 2016 The results showed the practice was performing above local and national averages. Of the 243 survey forms distributed, 122 were returned. This represented 2.5% of the practice's patient list.

- 98% of patients found it easy to get through to this practice by phone compared to the national average of 73%.
- 91% of patients were able to get an appointment to see or speak to someone the last time they tried compared to the national average of 76%.
- 92% of patients described the overall experience of this GP practice as good compared to the national average of 85%).
- 87% of patients said they would recommend this GP practice to someone who has just moved to the local area compared to the national average of 79%.

As part of our inspection we asked for Care Quality Commission comment cards to be completed by patients prior to our inspection. We received 27 comment cards which were all positive about the standard of care received. Patients told us they were treated very well, the staff were friendly and helpful and the treatment received was excellent.

We spoke with four patients during the inspection. All patients said they were more than satisfied with the care they received and thought staff were approachable, committed and caring. Patients told us the new appointment system exceeded expectations.

We looked at NHS Friends and Family Test results where patients are asked if they would recommend the practice. The results, from April 2015, showed 99% of respondents would recommend the practice to their family and friends.

We looked at the NHS Choices website to look at comments made by patients about the practice. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We saw there was one positive review in the past year.

Areas for improvement

Action the service SHOULD take to improve

- The practice should compile a full list of staff immunity against infectious diseases.
- The practice should improve the completion of incidents reporting forms.

Millbrook Surgery - Castle Cary

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser, a practice nurse specialist adviser and a second CQC inspector.

Background to Millbrook Surgery - Castle Cary

The practice (Millbrook Surgery) is located in Castle Cary; a small town located eight miles south of Shepton Mallet and 15 miles from Glastonbury, in the district of south Somerset. The practice provides primary medical services for the surrounding rural villages and hamlets which includes care and treatment to 93 patients living in eight residential and nursing homes.

The practice is located in a purpose built building completed in 2011. The practice has one branch surgery in Keinton Mandeville, a village in the southeast of Somerset, where an open access surgery is available each weekday morning in the village hall. During our inspection we did not visit the branch surgery.

The practice has a population of approximately 4900 patients. The practice has a slightly higher than England average of patients aged from 60 years of age onwards. The practice is situated in an area with lower deprivation with a deprivation score of 13 compared to Somerset Clinical Commissioning Group (CCG) average of 18 and the national average of 22.

The practice team includes two GP partners, (female and male), a part time salaried GP and a locum GP. In addition two female practice nurses, two health care assistants, a practice manager, four health coaches and administrative staff which include an IT lead, receptionists and secretaries are employed. At the time of our inspection the practice manager was not available.

The practice is a training practice trainee doctors and GPs. At the time of our inspection a trainee GP was being supported by the practice.

The practice had a General Medical Services contract (GMS) with NHS England to deliver general medical services. The practice provided enhanced services which included facilitating timely diagnosis and support for patients with dementia; extended hours opening; childhood immunisations and minor surgery.

Millbrook Surgery has been a first wave pilot for the primary care part of the NHS Vanguard joint venture, developing an Enhanced Primary Care model. In addition the practice has been part of the south Somerset health community since 2015. The project, developed by primary and secondary health care teams and the District Council incorporates social care, and community services. Part of this project, called Symphony, involves redesigning services for patients with complex needs and focusing on them in a 'virtual hub', based at Yeovil District Hospital. It also involves patients, carers, and voluntary organisations.

The practice is open between 8.30am to 6.30pm Monday to Friday with extended morning surgeries twice weekly from 7.30am and an extended evening surgery until 7pm once weekly.

Detailed findings

The national GP patient survey (January 2016) reported patients were satisfied with the opening times and making appointments. The results were slightly above local and national averages.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 and an Out Of Hours GP service is available to patients.

In February 2014 the Care Quality Commission carried out a routine inspection to check that essential standards of quality and safety were being met. We looked at five essential standards of quality and safety and found the standard was being met in that the provider was compliant with the Health and Social Care Act 2008 and relevant regulations.

Why we carried out this inspection

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

How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 May 2016. During our visit we:

- Spoke with a range of staff including GPs, practice nurses, health coaches, administrative and reception staff and the practice manager.
- Spoke with patients who used the service including the patient participation group.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed an anonymised sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.
- Spoke to organisations who work with the practice including the clinical commissioning group, the leg ulcer service and district nursing service.

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 were provided for specific groups of people and what good care looked like for them. The population groups are:

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

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

Good

Are services safe?

Our findings

Safe track record and learning

There was a system in place for reporting and recording significant events.

- Staff told us they would inform the practice manager of any incidents and there was a recording form available on the practice's computer system. The incident recording form supported the recording of notifiable incidents under the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment).
- Significant events and incidents were discussed at the weekly GP meeting and bi-monthly practice meeting.
- We saw evidence, when things went wrong with care and treatment, patients were informed of the incident, received reasonable support, truthful information, a written apology and were told about any actions to improve processes to prevent the same thing happening again.

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence lessons were shared and action was taken to improve safety in the practice. For example, the practice had concerns over medicine errors from a local pharmacy. The practice involved the local clinical commissioning group and the pharmacy in the investigation and joint processes were put in place to reduce errors. We saw, when a vaccine had been administered in error the practice had followed correct national processes, they notified the national patient safety team and informed the patient.

The practice had some inconsistencies in terms of significant events being documented within a central system. For example, we saw an inconsistency in the completion of reporting forms. We also saw a recent needle stick injury had been recorded in an accident book and a thorough investigation taken with lessons and actions put in place. The practice had not completed a significant event process.

Overview of safety systems and processes

The practice had clearly defined and embedded systems, processes and practices in place to keep patients safe and safeguarded from abuse, which included:

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policies clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. We saw good examples of staff referring children at risk and vulnerable adults including domestic abuse into local safeguarding processes. The GPs attended safeguarding meetings when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. We were told GPs were trained to child safeguarding level 3.
- A notice in the waiting room advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received or were in the process of undertaking a Disclosure and Barring Service (DBS) check. (DBS
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. We spoke to the area manager for the cleaning contractor who was able to evidence monthly audits and a thorough cleaning schedule and system. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control protocol in place and staff had received up to date training. Annual infection control audits were undertaken and we saw evidence action was taken to address any improvements identified as a result. The practice did not hold a list of all staff immunisations against infectious diseases with the exception of Hepatitis B. Records were held by individual staff.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Blank prescription forms and pads were securely stored and there were systems in place to monitor their use. However, we spoke to the practice about added

prescription security. This was because during our inspection, we saw two consulting rooms were unlocked. We spoke to the practice and changes to procedures were immediately rectified to ensure security of blank prescriptions. During our inspection the practice amended the policy and implemented changes to improve security. Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy team, to ensure prescribing was in line with best practice guidelines for safe prescribing. We spoke to the CCG pharmacist who told us the practice had good medicines safety, were proactive in reviewing medicine alerts and they adhered to policy. Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation.

- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them. There were arrangements in place for the destruction of controlled drugs.
- We reviewed three personnel files and found 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.

Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. There was a health and safety policy available with a poster in the reception office which identified local health and safety representatives. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).
- We saw the practice had a system for checking emergency lighting and fire alarms. We spoke to the practice about improving this system so a more robust checking and recording system was in place. Following our inspection the practice provided evidence of processes put in place to record the checking of fire equipment. We saw staff had not received up to date fire training. We saw evidence following inspection the practice had reviewed fire safety with an external organisation and training was imminently planned.
- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty.

Arrangements to deal with emergencies and major incidents

The practice had adequate arrangements in place to respond to emergencies and major incidents.

- There was an instant messaging system on the computers in all the consultation and treatment rooms which alerted staff to any emergency.
- All staff received annual basic life support training. The practice had a defibrillator available on the premises and oxygen with adult and children's masks. A first aid kit and accident book were available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. However emergency medicines were not kept with emergency equipment. All the medicines we checked were in date and stored securely. However we asked the practice to review emergency medicines with regards to access to emergency medicines for trainee GPs on home visits and ensuring medicines were located with emergency equipment.

The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff. Staff told us about a recent incident when the practice had no electricity for two hours. Staff were able to describe how they kept the practice open and functioning during this time.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The practice assessed needs and delivered care in line with relevant and current evidence based guidance and standards, including National Institute for Health and Care Excellence (NICE) best practice guidelines.

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- New guidance and standards were discussed at the weekly GP meeting. We saw the practice regularly amended guidance to reflect best practice.
- The practice monitored these guidelines were followed through risk assessments, audits and random sample checks of patient records.

Management, monitoring and improving outcomes for people

The practice participated in a local quality and outcomes framework, Somerset Practice Quality Scheme (SPQS) rather than the Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice). The practice used the information collected for the SPQS and performance against national screening programmes to monitor outcomes for patients.

We saw the practice continued to monitor the same quality of support and care as the national quality and outcomes framework, QOF. The most recent published results were 99% of the total number of points available.

This practice was not an outlier for any SPQS (or other national) clinical targets. Data from 2015/16 showed:

- Performance for diabetes related indicators was similar to the national average.
- Performance for mental health related indicators was lower than the national average. We spoke to the practice and they told us about their criteria for recording. In addition the SPQS framework required different quality measurements. We spoke to the practice who were able to evidence effective treatment in line with national guidance. We saw 100% of patients experiencing poor mental health who attended accident and emergency were followed up by the practice received a telephone call from a health coach.

There was evidence of quality improvement including clinical audit.

- There had been various clinical audits completed in the last two years, all of these were completed audits where the improvements made were implemented and monitored. For example, an audit on diabetic patients prescribed statin medicines; an annual family planning audit; annual minor surgery audits and fortnightly antibiotic prescribing audits. We reviewed six audits in detail. We saw evidence each audit undertaken contained a list of actions to be implemented after the audit.
- The practice participated in local audits, national benchmarking, accreditation, peer review and research. For example, clinical commissioning group prescribing scorecard audits to review the local required indicators of prescribing cost effectiveness.
- Findings were used by the practice to improve services. For example, an audit undertaken to identify patients at risk of harm from osteoporosis resulted in actions to review patients living in care homes and to assess whether primary preventative treatment for fractures was needed.
- The practice undertook weekly searches and had effective systems in place to monitor practice performance. For example, weekly searches were undertaken on hospital discharges and prevalence of diseases.

Each GP undertook a lead role in disease areas in order to improve care and treatment for those population groups. For example, GPs led in mental health, learning disability and respiratory diseases. The practice told us they were an early adopter of pilot studies in order to improve patient outcomes. We saw evidence of how practice involvement with pilot studies and joint ventures were improving patient care. For example, one study provided patients awaiting admission to hospital for routine operations were able to have their pre-operative tests and investigations carried out by the practice. This meant patients did not have to travel distances to the district hospitals.

Effective staffing

Good

Are services effective?

(for example, treatment is effective)

Staff had the skills, knowledge and experience to deliver effective care and treatment.

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety, health and safety and confidentiality.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions. One practice nurse had undertaken a MacMillan course to support patients with a new cancer diagnosis.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings. Practice nurses undertook annual cervical smear audits to assess their competence in sample taking.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support, one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.
- We saw GPs sat in the reception area after surgery to provide support and guidance for health coaches. The practice employed four health coaches to improve services for vulnerable patients. Additional support and external training had been provided to support them in their role.
- We saw staff had opportunities to progress within the practice. For example, one health coach had started as a receptionist, undertaken training as a phlebotomist then a health care assistant prior to receiving college based training to become a health coach.
- Staff received training that included: dementia, safeguarding, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. We saw fire safety awareness training required updating. Following our inspection we saw evidence fire safety awareness training had been organised.
- The practice had a good process in place to handover patient caseloads when GP trainees completed their placement. For example, GP trainees would provide a comprehensive written handover.

Coordinating patient care and information sharing

The information needed to plan and deliver care and treatment was available to relevant staff in a timely and accessible way through the practice's patient record system and their intranet system.

- This included care and risk assessments, personalised, comprehensive care plans, medical records and investigation and test results.
- The practice shared relevant information with other services in a timely way, for example when referring patients to other services; and when patients required end of life care.

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with other health care professionals where care plans were routinely reviewed and updated for patients with complex needs. For example, the practice met weekly with the community psychiatric nurse, monthly with the district nurses and palliative care team and bimonthly with health visitors and school nurses.

In addition fortnightly child safeguarding meetings took place. Vulnerable adults were discussed at the twice weekly 'Huddle' which is attended by all the practice staff. The meeting was staff led with staff taking turns to chair the meeting. We attended the meeting where a wide range of patients with social and medical vulnerabilities were discussed, including those currently in hospital. We saw health coaches had up to date patient knowledge through contact with patients and through attendance at other organisation multi-disciplinary meetings.

Consent to care and treatment

Good

Are services effective?

(for example, treatment is effective)

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (2005).
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment.
- The process for seeking consent was monitored through patient records audits.

Supporting patients to live healthier lives

The practice identified patients who may be in need of extra support. For example:

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation and blood pressure. Patients were signposted to the relevant service.
- Smoking cessation advice was available from a local support group.
- Patients at risk of a stroke were identified and invited to a series of stroke prevention meetings.
- Vulnerable patients were identified through community networks and referred to the practice 'huddle'. Isolated and vulnerable patients were provided with information and support to join social groups and activities. For example, singing for the brain.
- Pedometers were available for patient use.

The practice's uptake for the cervical screening programme was 83% which was comparable to the clinical commissioning group (CCG) average of 81% and the national average of 82%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. There were failsafe systems in place to ensure results were received for all samples sent for the cervical screening programme. The practice demonstrated how they encouraged uptake of the screening programme by using information in different languages and for those with a learning disability and they ensured a female sample taker was available.

The practice encouraged patients to attend national screening programmes for bowel and breast cancer screening. Data showed screening for bowel cancer was in line with local and national averages. Screening for breast cancer was 71% which was slightly below the national average of 72%.

Childhood immunisation rates for the vaccines given were comparable to the CCG and national averages. For example, childhood immunisation rates for the vaccines given to under two year olds ranged from 83% to 98%, the CCG average was 82% to 97%) and five year olds from 91% to 94%, the CCG average was 93% to 97%).

Patients had access to appropriate health assessments and checks. NHS health checks for patients aged 40–74 were commissioned elsewhere. Appropriate follow-ups for the outcomes of health assessments and checks were made, where abnormalities or risk factors were identified.

Good

Are services caring?

Our findings

Kindness, dignity, respect and compassion

We observed members of staff were courteous and very helpful to patients and treated them with dignity and respect.

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- We noted consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew when patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.

All of the 27 patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect. Comment cards highlighted that staff responded compassionately when they needed help and provided support when required.

We spoke with one member of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

Results from the national GP patient survey (January 2016) showed patients felt they were treated with compassion, dignity and respect. The practice was in line with or above local and national averages for satisfaction scores on consultations with GPs and nurses. For example:

- 91% of patients said the GP was good at listening to them compared to the clinical commissioning group (CCG) average of 92% and the national average of 89%.
- 90% of patients said the GP gave them enough time compared to the CCG average of 89% and the national average of 87%.
- 97% of patients said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and the national average of 95%.
- 97% of patients said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.
- 98% 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 the national average of 91%.
- 89% of patients said they found the receptionists at the practice helpful compared to the CCG average of 89% and the national average of 87%.

Care planning and involvement in decisions about care and treatment

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

Results from the national GP patient survey (January 2016) showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment. Results were in line with local and national averages. For example:

- 88% of patients said the last GP they saw was good at explaining tests and treatments compared to the clinical commissioning group (CCG) average of 90% and the national average of 86%.
- 91% 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% and the national average of 82%.
- 92% of patients said the last nurse they saw was good at involving them in decisions about their care compared to the local average of 88% and the national average of 85%.

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

- Staff told us translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.
- Information leaflets were available in easy read format.
- The practice undertook virtual clinics, for example, diabetic clinics with the diabetic specialist nurse and specialist doctor to empower diabetic patients through education.

Good

Are services caring?

Patient and carer support to cope emotionally with care and treatment

Patient information leaflets and notices were available in the patient waiting area which told patients how to access a number of support groups and organisations. Information about support groups were available on the practice website.

The practice's computer system alerted GPs if a patient was a carer. The practice had identified 77 patients as carers (1.5% of the practice list). The practice had a carer's champion who had received additional training. The carer's champion contacted carers to provide support disseminate information and sign post carers and patients to support groups. Written information was also available to direct carers to the various avenues of support available to them.

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

The health coaches provided additional support to help patients and their families cope with wellbeing changes. For example, staff told us how they had supported a family during the transition of a patient from home to a residential home.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Somerset Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. For example, the practice worked with the CCG to reduce medicines budgets by 2% in 15 months.

In 2015 the practice became a part of the south Somerset health community. This is a partnership of Yeovil District Hospital NHS Foundation Trust, Somerset CCG, South Somerset Healthcare GP Federation and Somerset County Council that are working to deliver an integrated primary and acute care system. The process also involves patients, carers, and voluntary organisations.

Part of this project, called Symphony, involves redesigning services for patients with complex needs and focusing on them in a 'virtual hub', based at Yeovil District Hospital. Millbrook Surgery has been a first wave pilot for the primary care part of the Joint Venture, developing an enhanced primary care model. The impact on patient care is yet to be evaluated by the project.

The practice employed four health coaches who offered support to patients and their families of any age who had recently been discharged from hospital, had a chronic condition, and were vulnerable or isolated. For example, health coaches provided lifestyle advice, assistance with day to day tasks, access and referral to community services, support and care packages and personalised care plans for those at risk. Every patient discharged from hospital received a phone call within three days of returning home. The health coaches received referrals from other services, the local community, patients and staff and from picking up information at reception. For example, the local community accessible transport drivers would share concerns about individual patients allowing for improved quality of life. We saw patients responded positively to the service and praised staff. Since the introduction of health coaches the practice were able to evidence a reduced impact on GP appointments.

The practice held a twice weekly 'huddle' meeting for all staff. The meeting enabled any member of staff with a concern about a patient to communicate it to the rest of the team and included a discussion of patients currently being managed by the health coaches. This meant the practice could be proactive and responsive to an individual patient's care and treatment. We attended the 'huddle' and saw a wide range of patients with social and health concerns, including those patients due to be discharged from hospital, being discussed. The practice had a register of all patients discussed at the 'huddle' which included required actions and a timeframe to discuss the patient again. We saw actions were completed within agreed timeframes.

In addition:

- The practice offered a 'Commuter's Clinic' on a Tuesday and Thursday morning and a Thursday evening until 7pm for working patients who could not attend during normal opening hours.
- There were longer appointments available for patients with complex needs, multiple illnesses, a learning disability and any other concern that required one.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- A weekly ward round was provided for a residential home for people with a diagnosis of dementia.
- Patients could telephone the practice and speak to a GP on the day. Same day appointments were available for patients that needed to be seen by a GP. We saw this was usually with the GP of their choice.
- Patients were able to receive travel vaccines available on the NHS, those only available privately were referred to other clinics.
- There were accessible disabled facilities, a hearing loop, translation services and a sign language interpreter available.
- The practice had a reciprocal arrangement with a local GP practice for the fitting of intrauterine devices (coils).
- The practice hosted the leg ulcer clinic for anyone in the local area to attend.

Access to the service

The practice was open between 8.30am and 6.30pm Monday to Friday. Appointments were from during the opening hours. Extended hours appointments were offered on Tuesday and Thursday mornings from 7.30am and Thursday evenings until 7pm (for GPs and practice nurses).

Good

Are services responsive to people's needs?

(for example, to feedback?)

In addition pre-bookable practice nurse appointments could be booked up to six weeks in advance; urgent appointments were available for patients that needed them.

In February 2016 following patient and staff concerns around patient waiting times for routine appointments and patient access to the practice (as patients phoning for an urgent appointment on the day meant phone lines were busy when the practice opened) the practice commenced an open access system. Patients had access to same day appointments, when needed, with the GP of their choice.

The open access system allows patients to phone the practice and await a call back from a GP. Audits show the call back time is no longer than one and a half hours. Patients can then receive care over the phone or attend for an appointment. This meant patient concerns or ill health were dealt with on the day. In addition a process was in place for reception staff to identify those patients requiring urgent care. Staff told us the system worked well as it reduced pressure on appointments and GPs. Staff told us that it enabled GPs to speak to patients and if necessary organise tests such as blood tests, and then book the patient in a few days later. Patients told us they were impressed with the new system and felt it was more responsive to their needs as they were able to get appointments when they needed them and received appointments within a short timeframe from their initial call to the practice.

Results from the national GP patient survey (January 2016) showed patient's satisfaction with how they could access care and treatment was significantly better than local and national averages. (These patient survey results were prior to the new open access appointment system).

- 79% of patients were satisfied with the practice's opening hours compared to the clinical commissioning group (CCG) average of 78% and the national average of 78%.
- 98% of patients said they could get through easily to the practice by phone compared to the CCG average of 78% and the national average of 73%.

The practice had a system in place to assess whether a home visit was clinically necessary and

the urgency of the need for medical attention. In cases where the urgency of need was so great that it would be inappropriate for the patient to wait for a GP home visit, alternative emergency care arrangements were made. Clinical and non-clinical staff were aware of their responsibilities when managing requests for home visits.

We saw the practice was continuing to monitor the new open access appointment system at weekly meetings. The practice had completed an audit ten weeks post implementation looking at patient access and demand for appointments prior to and after implementation. In addition a patient survey had been conducted six weeks after the new system commenced with 86% of patients saying they were much happier with the service.

Listening and learning from concerns and complaints

The practice had an effective system in place for handling complaints and concerns.

- The complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England.
- There was a designated responsible person who handled all complaints in the practice.
- Complaints were discussed at the weekly GP meeting.
- We saw information was available to help patients understand the complaints system. For example, information was available on the practice website and within the waiting area.

We looked at the one complaint received in the last 12 months and found this was satisfactorily handled in a timely way. We saw the practice was open and transparent with dealing with complaints. Lessons were learnt from concerns and complaints and from analysis of trends and action was taken to as a result to improve the quality of care. We saw the practice generally dealt with any verbal concerns or comments at the time.

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.

- The practice had a mission statement and staff knew and understood the values.
- The practice had a robust strategy and supporting business plans which reflected the vision and values and were regularly monitored.
- The practice had a statement of purpose which included an aim to provide a high standard of medical care; maintain high quality of care through continuous learning and training; treat all patients and staff with dignity, respect and honest and to improve as a patient centred service through decision making and communication.
- The practice had a 'vision for the future' strategy in place. This included plans to recruit a pharmacist and a practice based musculoskeletal service.

Governance arrangements

The practice had an overarching governance framework which supported the delivery of the strategy and good quality care. This outlined the structures and procedures in place and ensured:

- There was a clear staffing structure and staff were aware of their own roles and responsibilities.
- Practice specific policies were implemented and were available to all staff.
- A comprehensive understanding of the performance of the practice was maintained.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements.
- There were arrangements for identifying, recording and managing risks, issues and implementing mitigating actions. In some areas we saw the practice could make improvements. For example, recording of fire alarm and emergency lighting checks and the recording of all significant events in one place. The practice responded to all issues identified and after the inspection provided evidence that improvements had been made.
- The partners and practice manager met weekly to discuss business management and governance.

Leadership and culture

On the day of inspection the partners in the practice demonstrated they had the experience, capacity and capability to run the practice and ensure high quality care. They told us they prioritised safe, high quality and compassionate care. Staff told us the partners were approachable and always took the time to listen to all members of staff.

The provider was aware of and had systems in place to ensure compliance with the requirements of the duty of candour. (The duty of candour is a set of specific legal requirements that providers of services must follow when things go wrong with care and treatment). This included support and training for all staff on communicating with patients about notifiable safety incidents. The partners encouraged a culture of openness and honesty. The practice had systems in place to ensure when things went wrong with care and treatment:

- The practice gave affected people reasonable support, truthful information and a verbal and written apology.
- The practice kept written records of verbal interactions as well as written correspondence.

There was a clear leadership structure in place and staff felt supported by management.

- Staff told us the practice held regular individual and whole team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. We noted team away days were held annually.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.
- Feedback from other organisations such as Somerset Clinical Commissioning group and staff working for the integrated community healthcare organisation described the partners as engaged and responsive with a commitment to improve the patient's quality of care.

Are services well-led?

Good

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

For example, the practice hosted a leg ulcer treatment clinic for the local area. This meant older and vulnerable people living within the area did not have to travel outside of the area for regular treatment.

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

The practice encouraged and valued feedback from patients, the public and staff. The practice proactively sought patients' feedback and engaged patients in the delivery of the service.

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met regularly, carried out patient surveys and submitted proposals for improvements to the practice management team. For example, the practice had installed a water cooler following patient requests; the PPG had asked for better display of patient information and the practice had installed a television screen in the waiting room to provide this; and the patient survey highlighted a need for extended hours and the practice had provided these.
- We saw patient surveys were planned well in advance. For example, the next patient survey was planned to evaluate patient experiences around the open access system.
- The practice had evaluated patient feedback from a previous CQC inspection. We saw the actions the practice had taken to resolve concerns. For example, a room had been provided for patients to speak to staff in confidence.
- The practice kept patients up to date with quarterly newsletters and information on the website.
- The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussion. 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, valued, involved and engaged to improve how the practice was run.
- Following the implementation of the open access appointment system the partners had listened to concerns from staff and patients. As a result they had implemented changes. For example, exceptions were made for some patients with regards to booking routine appointments; and additional support was provided to trainee GPs to manage the system.

Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area:

- We saw the practice had been involved in a pilot for pre-operative hospital assessments to be undertaken at the practice. This meant patients who relied on poor public transport systems, family or friends could have pre-operative tests and investigations completed locally instead of travelling to district hospitals.
- The practice set up a local IT leads group to improve quality outcomes in local practices. The IT Lead was attending a clinical governance data management course to improve quality recording within the practice.
- Virtual clinics were set up with hospital specialists' to improve care and treatment of patients. This meant the patients affected by a poor public transport system, patients with poor management of their condition or those with dependents such as carers had improved access to care.
- The practice is part of the integrated hospital and primary care vanguard with one GP providing leadership by acting as vice chair of the project.
- The practice had been responsive to staff and patient comments around patient access to appointments through the open access system and the employment of health coaches. We saw evidence of the resulting benefits to patients.