Glastonbury Health Centre

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

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Glastonbury Health Centre Surgery on 10 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, effective, caring, responsive and well led services. It was also good for providing services for older people, people with long-term conditions, mothers, babies, children and young people, the working-age population, including students and those recently retired, people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

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.
- The practice worked well with other services to provide treatment and support for patients who have a diagnosis of a mental healthcondition.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they were able to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.
- The practice are one of five practices nationally that have a PMS plus contract for Complementary Services

(osteopathy and acupuncture). This service has met the need for effective alternative therapy and reducing referrals to conventional therapists (physiotherapists/ orthopaedics) for chronic muscular skeletal pain. This service meets their patient group expectation for complementary therapies and NICE guidelines.

We saw several areas of outstanding practice including:

- The newly developed Health Connections Mendip service which was partly facilitated by Glastonbury Health Centre and another local medical practice, to build patient confidence and self- reliance in managing their own conditions and use services available to them for support.
- The practice has a programme in place to avoid unplanned admissions to hospital.
- Daily same day clinics with a medical team consisting of GP and Nurse practitioner are provided. The Extended Surgery service offers appointments with GPs, Nurses and HCA 6.30 pm to 7.15pm one evening per week.

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?

The practice is rated as good for providing safe services. There were enough staff to keep patients safe. 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.

Good

Are services effective?

The practice is rated as good for providing effective services. 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. The practice is part of the federation Health Connections Mendip which provides guidance, support and advice to patients and support services at the health centre including; 'Healthy Mondays', Friday walking group, monthly Age UK, CAB and Jobcentre clinics. NHS Health Checks are undertaken in line with identified patient need. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. There was evidence of appraisals and personal development plans for all staff. Staff worked with multidisciplinary teams.

Good

Are services caring?

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

The practice had developed ways of identifying patients who had additional needs and supporting them such as a practice weekly walking group to help patients who were seeking exercise strategies, had mental health issues or bereaved. Information to support health promotion was available.

Good

Summary of findings

Are services responsive to people's needs? The practice is rated as good for providing responsive services. Patients said they found there was continuity of care, with urgent appointments available the same day. The practice location had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.	**Good**
Are services well-led? 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.	**Good**

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

The practice is rated as good for the care of older people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs. The practice had implemented named GPs to lead care and support to patients living in care or nursing homes.

Good

People with long term conditions

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

Good

Families, children and young people

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk. The practice had recognised that childhood immunisation rates for vaccinations was below the expected target levels and had been working with Public Health England to improve the take up. What they had identified was the difficulties of reaching patients with alternative lifestyles where conventional medicine and treatment is not used readily or those who had difficulty accessing healthcare. Patients told us that children and young people were treated in an age-appropriate way and were recognised as individuals. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses.

Good

Working age people (including those recently retired and students)

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

Good

been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. Daily same day clinics with a medical team consisting of GP and Nurse practitioner are provided. The Extended Surgery service offers appointments with GPs, Nurses and HCA 6.30 pm to 7.15pm one evening per week.

The practice was proactive in offering online services as well as a full range of health promotion and screening that reflected the needs for this age group.

People whose circumstances may make them vulnerable

Good

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

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia). People experiencing poor mental health had received an annual physical health check. The practice had identified 54 patients who had been diagnosed with dementia of which 32(59%) had been assessed and placed on an avoid unplanned hospital admission list. 52 of patients had been seen by a GP more than three times within the past year. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those people living with a diagnosis of dementia.

The health centre had the highest registration of patients with mental health problems in Somerset. The health centre is the only practice in the area that accommodates patients with substance misuse supporting a ‘shared care’ service with Somerset Drug and Alcohol Service.

Summary of findings

The practice had signposted patients experiencing poor mental health about how to access various support groups and voluntary organisations. It worked well with other mental health services and practitioners and there was a shared approach to providing care to people.

Summary of findings

What people who use the service say

We spoke with one patient during the day. We also spoke with four members of the Patient Participation Group. We received information from the seven Care Quality Commission comment cards left at the practice.

Patients told us they always found the practice clean and had no concerns about cleanliness or infection control.

Information showed that patients were satisfied with how they were treated and this was reflected in the comments we received. Information from mental health teams who came in contact with the practice said they had experienced that the staff they have had contact with were experienced in mental health, were compassionate and really do want the most effective treatment for their clients.

Patients said they felt the practice offered an excellent service and staff were understanding, efficient, helpful and caring. They said staff treated them with dignity and respect. One patient expressed their satisfaction about the support their whole family had received over a number of years they had been attending the practice.

We saw that feedback was very positive, for example from the friends and family test 85% of respondents' were 'extremely likely' and 9% were 'likely' to recommend the practice to friends and family.

Outstanding practice

We saw several areas of outstanding practice including:

- The newly developed Health Connections Mendip service which was partly facilitated by Glastonbury Health Centre and another local medical practice, to build patient confidence and self- reliance in managing their own conditions and use services available to them for support.
- The practice has a programme in place to avoid unplanned admissions to hospital.
- Daily same day clinics with a medical team consisting of GP and Nurse practitioner are provided. The Extended Surgery service offers appointments with GPs, Nurses and HCA 6.30 pm to 7.15pm one evening per week.

Glastonbury Health Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector and included a GP specialist advisor.

Background to Glastonbury Health Centre

Glastonbury Health Centre, 1 Wells Road, Glastonbury, BA6 9DD is situated in the town centre of Glastonbury. The practice had approximately 6,400 registered patients from Glastonbury and the surrounding areas.

The practice is located in purpose built premises (2012).The main patient areas of the practice are situated on the ground floor of the building. The two consulting rooms situated on the first floor are accessible by lift or stairs. The patient waiting room, a reception desk and a patient health check area are to the front of the building. Consulting and treatment rooms lead off these areas. Administration, management and meeting rooms are located on the first floor of the building. The practice is on a personal medical service contract with Somerset Clinical Commissioning Group.

The practice supports patients from all of the population groups such as older people, people with long-term conditions, mothers, babies, children and young people, working-age population, including students and those recently retired; people in vulnerable circumstances who may have poor access to primary care and people experiencing poor mental health.

Over 35% of patients registered with the practice were working aged from 15 to 44 years, 33.3% were aged from 45 to 64 years old. Of those patients the health centre has a higher than average (within England) of 45-57 year olds. Just below 10% were over 65 years old. Around 4.5% of the practice patients were 75-84 years old and 1.9% of patients were over 85 years old. Just below 15% of patients were less than 14 years of age. Information from NHS England showed that 64.7% of the patients had long standing health conditions, which was above the national average of 54%. The percentage of patients who had caring responsibilities was 21.2% which is above the national average of 18.5%. Just below 5% of the working population were unemployed which is below the national average of 6.2%.

The practice consisted of four GP partners. Of these four GPs there were two male and two female GPs. There was a nurse practitioner, pharmacist, three practice nurses and two health care assistants all of whom provided health screening and treatment five days a week. The practice offers patients access to an acupuncturist and an osteopath. GP registrars completing their training may be at the practice and other healthcare and administration staff could be on secondment or training at the practice. There was a team of administration, reception and secretarial staff. The practice had a full time practice manager who was in charge of the day to day management of the service.

Glastonbury Health Centre had core hours of opening from 8.00am to 6.30pm every weekday; they remained open until 7.30pm on Wednesdays. The practice referred patients to another provider NHS 111, and then Somerset Doctors Urgent Care Service for an Out of Hour's service to deal with any urgent patient needs when the practice was closed.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

The practice provided us with information to review before we carried out an inspection visit. We used this, in addition to information from their public website. We obtained information from other organisations, such as the local Healthwatch, the Somerset Clinical Commissioning Group (CCG), and the local NHS England team. We looked at recent information left by patients on the NHS Choices website.

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

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

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

- Older people
- People with long-term conditions
- Mothers, babies, children and young people
- The working-age population and those recently retired
- People in vulnerable circumstances who may have poor access to primary care
- People experiencing poor mental health.

During our visit we spoke with three of the GPs, the nurse practitioner, and two practice nurses. We also spoke with the practice manager and the reception and administration staff on duty. We met contractors and reviewed information for cleaning and maintenance of the building. We spoke with one patient in person during the day. We also spoke with four members of the Patient Participation Group. We received information from the seven Care Quality Commission comment cards left at the practice.

On the day of our inspection we observed how the practice was run, such as the interactions between patients, carers and staff and the overall patient experience.

We also obtained feedback from representatives of local care services who came in contact with the surgery. We heard from the local hospital, walk in centre and social services team of whom the practice staff work with on a regular basis. We also had received information from a locum GP who had recently worked at the practice.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, detail of a patient's care needs was missed when transferred from hospital to home and back under the care of the surgery. Regular blood testing was not highlighted as being needed to be carried out in their on-going plan of care. Checks were implemented to be carried out by administration staff to ensure the correct coding was placed on patients records and to prompt GPs attention to information received in the practice.

We reviewed safety records, incident reports and minutes of meetings where these were discussed and shared with all staff. This showed the practice had managed these consistently over time and so could show evidence of a safe track record over the long term. A GP partner lead and the practice manager shared responsibility of monitoring significant events at the practice.

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 nine significant events that had occurred during the last 12 months and saw this system was followed appropriately. Significant events were a standing item on practice meeting agendas. There was evidence that the practice had learned from these and that the findings were shared with relevant staff or outside organisations where necessary. For example, following an unexpected death a review of the care and treatment provided to a patient who had shared care with a drug and alcohol misuse service Staff, including receptionists, administrators and nursing staff, all knew how to raise an issue for example when a vaccine fridge door had been left open, the medicines were discarded as they were no longer safe for use and actions put in place in order to prevent reoccurrence.

Staff provided information about the system used to manage and monitor incidents which showed that where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the member of staff identified as the prescribing lead. The prescribing receptionist raised alerts to all prescribers and other relevant practice staff. This information was cascaded to relevant staff via email and the information was saved electronically for staff to refer to. We were told alerts were discussed at practice meetings.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that most staff had received relevant role specific training on safeguarding or it was planned for within the near future. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. The practice regularly reviewed and updated its policies and procedures and ensured that all staff were aware of any changes made.

The practice had appointed a dedicated GP as lead in safeguarding vulnerable adults and another for children. 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 practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example nursing and administration staff described how patients were 'flagged' with pop ups when their records were accessed. This meant they were able to respond appropriately such as alerting the GP that information had been received. There was active engagement in local safeguarding procedures

and effective working with other relevant organisations including health visitors and school nurses. We were told there were regular monthly meetings where information was shared and a planned approach was discussed.

There was a chaperone policy, which was visible on the waiting rooms noticeboards and in consulting rooms. (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). Most nursing staff, including health care assistants, and some administration 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 and were only accessible to authorised staff. There was a policy for ensuring that medicines were kept at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and 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. There was a central stock-taking system. The practice pharmacist undertook regular audits of all medicines systems in place. 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.

The practice had clear systems in place to monitor the prescribing of controlled medicines (medicines that require extra checks and special storage arrangements because of their potential for misuse). Staff were aware of how to raise concerns around controlled medicines with the controlled medicines accountable officer in their area. There were no controlled medicines kept at the practice.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated. A small number were waiting to be signed by the responsible GP before they were implemented. We saw evidence that nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a Patient Specific Direction (PSD) from the prescriber.

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

The practice have in place a medicine management team. This included prescription administrators and a pharmacist. This team have responsibility to implement the internal comprehensive Drug Safety Alert system with the National Drug & Appliance Alert System. They also have responsibility to ensure patient repeat prescription requests are safely issued and monitored, including supporting the medication review system

Cleanliness and infection control

We observed the premises were clean and tidy. We were told contractors were responsible for cleaning at the practice premises. We reviewed the cleaning schedules, policies and procedures and saw they followed appropriate guidance. There were good audit systems in place and the contractors liaised with the practice staff effectively. Patients 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. These were available on line. For example, in relation to personal protective equipment including disposable gloves, aprons

and coverings. We saw these were readily available for staff to use in all clinical areas. Staff were aware of the needle stick policy and procedures and these were on display prominently where required.

The practice had a lead for infection control. We were told they were able provide advice on the practice infection control policy and carry out audits, and staff training. All staff received induction training about infection control specific to their role and participated in on line annual updates. There was a regular programme of audits for infection control. Minutes of practice meetings such as the quarterly health and safety meeting showed that aspects of infection control, such as a hand hygiene audit, spot checks, planned training and actions taken to improve infection control practices 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 information available in regard to a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). This was carried out by the buildings maintenance contractor.

Equipment

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

Staffing and recruitment

The practice had recently reviewed and updated its recruitment policy. This new policy set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence that 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). We saw that detail of clinical staff's immunity status was kept with their employment records

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe.

Monitoring safety and responding to risk

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

Risk assessments were in place where risks were identified. Each risk was assessed and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were in place. There were specific quarterly health and safety meetings and minutes we reviewed showed risks were discussed across the staff teams. For example, fire safety, confidential waste and data protection. Learning needs were identified and actions put in place to implement them.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example there was a daily triage system to respond to patient's urgent care needs. Patients who were of concern or potential of concern were 'flagged' on the patient record system. Care plans were in place and shared with external health providers, such as the Out-of-Hours service.

Good

Are services safe?

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. Records showed that all staff had received training in basic life support. Emergency equipment was available including access to oxygen and an automated external defibrillator (used in cardiac emergencies). When we asked members of staff they all knew the location of this equipment and records confirmed that it was checked regularly.

We found emergency medicines were easily accessible to staff in a secure area of the practice locations. These medicines included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. 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 that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to. For example, contact details of the water company should there be a problem with water supply. We were told that copies of the contingency plan were held off site and were reviewed annually or when a change of contacts/ information occurred.

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

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We discussed with the practice manager and a GP how NICE guidance was received into the practice. They told us this was the responsibility of individual GPs to check and download information from the website. We were told the practice pharmacist also searched for new guidance and updates in regard to medicines management and passed this to the clinical staff at the practice. However, we were told there was no central system for systematic review of information/new guidance received in. We did see that the practice used the 'Somerset Pathway Navigator', an information service provided by Somerset Clinical Commissioning Group, which referred to NICE guidance and was updated weekly and 'pop ups' on each computer alerted staff to new information. We saw minutes of meetings which showed information was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. An example of using this guidance and changing practice was a new protocol was put in place for end of life care.

Staff described how they carried out comprehensive assessments of individual patients which covered all their 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, heart disease and chronic kidney disease were having regular health checks and were being referred to other services when required. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they lead in specialist clinical areas such as diabetes and chronic obstructive airways disease (COPD) and the practice nurses supported this work for patients with long term conditions. The GPs and nursing staff we spoke with were open about asking for and providing colleagues with advice and support. Nursing staff told us about and we saw evidence of sharing of information at practice meetings for developing best practice.

The practice told us they had commenced providing the 'avoiding unplanned admissions' enhanced service at the practice during 2014/15. An enhanced service is above what is required in the primary medical services contract. The practice used computer document tools to identify and plan for continuity of care for patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met. Patients who were perceived to be at risk and contacted the practice were either booked for a same day consultation or put on the duty doctor telephone list. If the call was urgent and needed immediate attention staff put a message on the duty doctors computer screen or put the call through to them. Equally, the practice had a system to review and follow up all patient admissions and discharges from hospital on a weekly basis.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information was used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling health checks and immunisations. The information staff collected was then collated by the practice manager to support the practice to carry out monitoring to check that targets were met and determine if more detailed audits were required. GPs told us about how other aspects of the service such as, an identified lower than the national average diagnosis and prevalence of patients with diabetes at the practice was responded to. This had triggered a review of symptoms and treatments already in place to ensure that patients had the correct diagnosis.

Good

Are services effective?

(for example, treatment is effective)

The practice told us about the clinical audits that had been undertaken in the last three years. Some were annual audits such as looking at one form of contraception. Another looked at the prescribing of a certain type of anti-coagulants used for preventing blood clots. The outcome from this audit was to implement systems to ensure that patients records were flagged up to alert the clinician to carry out checks/end treatment in a timely way The practice had carried out an audit on the use of chaperones at the practice which had resulted in changes made to how and when patients were reminded of the availability of a chaperone or offered one.

The practice also used the information collected for the Quality Outcomes Framework (QOF), the local Somerset Quality Practice Scheme and performance against national screening programmes to monitor outcomes for patients. The practice particularly used information from both schemes to assess meeting patients' needs for long term health conditions, such as diabetes, stroke and chronic heart disease. For example they had looked at the previous indicators for take up of seasonal influenza vaccines. For 2014/2015 they had exceeded their target range from between 95% - 97% to 95.2% - 98.8%.

The practice was aware of all the areas where there were gaps in performance compared with national or Clinical Commissioning Group figures. We saw that achieving targets was discussed at all levels of staff meetings and we saw actions were put in place setting out how these were being addressed.

The practice's prescribing rates were similar to national figures for example, the use of specific types of antibacterial medicines or antibiotics. They used information from the Somerset Clinical Commissioning Group to monitor and implement changes to their prescribing patterns. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice 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. We were provided with feedback from the community palliative care team who told us the GP's actively promoted and participated in monthly multi-disciplinary Gold Standard Framework (GSF) meetings. GSF is about giving the right person the right care, in the right place at the right time, every time. When patients or their carers telephoned the health centre and spoke with reception and administration staff the staff showed they cared and tried their very best to resolve enquiries and requests in a timely manner.

The practice also kept a register of patients identified as being at high risk of admission to hospital. The practice has an "Avoiding Unplanned Admissions programme". Care plans were completed for 2.5% patients identified on the practice 'at risk register' and patients were reviewed within a multidisciplinary team to reduce hospital admission. This enabled patient choice of their preferred place of death. Structured annual reviews were also undertaken for people with long term conditions. The practice had identified that it had above the average number, to the locality, of patients attending the practice with mental health needs. They had also identified that a good number of patients attending the practice had an alternative lifestyle where conventional medicine and treatment was not used readily. The practice supported people from the traveller community and was involved in providing healthcare support for a charitable organisation for homeless people. The practice had identified 54 patients who had been diagnosed as living with dementia of which 32(59%) had been assessed and put on the avoid unplanned admission list. All but two patients had been seen by GPs more than three times yearly.

The practice provided GP support to the local community hospital. We were told by a representative of the community hospital that the service worked well, patients' needs were met and the practice was responsive to their needs. The practice are one of five practices nationally that have a PMS plus contract for Complementary Services (osteopathy and acupuncture). This service has met the need for effective alternative therapy and reducing referrals to conventional therapists (physiotherapists/orthopaedics) for chronic muscular skeletal pain. The practice told us this service meets their patient group expectation for complementary therapies and NICE guidelines.

Good

Are services effective?

(for example, treatment is effective)

The practice is part of the federation Health Connections Mendip which provides guidance, support and advice to patients and support services at the health centre including eg 'Healthy Mondays', Friday walking group, monthly Age UK, CAB and Jobcentre clinics.

NHS Health Checks are undertaken in line with identified patient need.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that most staff were up to date with attending mandatory courses such as annual basic life support. Where there were gaps this was because they were still undergoing induction or the training was planned for. All GPs were up to date with their yearly continuing professional development requirements and all either had 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).

All staff undertook annual appraisals that identified learning needs from which some plans for personal development were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, on administration of vaccines and cervical cytology.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out-of-Hours GP services and the 111 service both electronically and by post. 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. A buddy system was in place if the GP wasn't present on the day. All staff we spoke with understood their roles and felt the system in place worked well. We saw from the daily clinical meetings examples of how joint and shared working was in place which assisted with reviewing information and decision making about patients care.

The practice held multidisciplinary team meetings fortnightly to discuss patients with complex needs. For example, those with multiple long term conditions and those with end of life care needs. These meetings were attended by district nurses, community matron, social workers, palliative care nurses and decisions about care planning were documented in a shared care record. The child protection lead met monthly with health visitors and school nurses where information and concerns were shared and discussed. This included regular working with Turning Point, a national health and social care provider, to support patients with substance abuse. 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.

Information sharing

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

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency.

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

Good

Are services effective?

(for example, treatment is effective)

Consent to care and treatment

We found that 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).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). Where difficult assessments were identified these were discussed with other members of the clinical team or external professionals involved with the patient.

There was a practice policy and 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.

Health promotion and prevention

It was practice policy to offer a health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs and nursing staff to use their contact with patients to help maintain or improve mental health, physical health and wellbeing. For example, by offering support such as smoking cessation advice to smokers and chlamydia screening for young people. The practice also provided access/referrals to other health promotion schemes outside of the practice.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. The practice worked with the Patient Participation Group (PPG) with health promotion campaigns and influenza vaccination clinics. The PPG told us their next project was looking at supporting the practice with promoting sexual health for young people.

The practice enabled patients to access national screening programmes. Cervical screening took place at the practice. There was a policy of reminders for patients who did not attend for their cervical screening test, pop up information was added to their patient record so that during ad hoc consultations this could be discussed and arranged. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. For example, influenza vaccination rates for the over 65s were 72%, which was similar to the national average. The practice had recognised that childhood immunisation rates for the vaccinations was below the expected target levels and had been working with Public Health England to improve the take up. What they had identified was the difficulties of reaching patients with alternative lifestyles where conventional medicine and treatment was not used readily or those who had difficulty accessing healthcare.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent information available for the practice on patient satisfaction. This included information from NHS Choices, friends and family test and any surveys carried out by the Patient Participation Group (PPG). Information was very positive, for example from the friends and family test 85% of respondents' were 'extremely likely' and 9% were 'likely' to recommend the practice to friends and family. We spoke with one patient in person during the day. We also spoke with four members of the Patient Participation Group. We received information from the seven Care Quality Commission comment cards left at the practice. Information showed that patients were satisfied with how they were treated and this was reflected in the comments we received. Information from mental health teams who came in contact with the practice said they had experienced that the staff they have had contact with were experienced in mental health, were compassionate and really do want the most effective treatment for their patients.

Patients said they felt the practice offered an excellent service and staff were understanding, efficient, helpful and caring. They said staff treated them with dignity and respect. One patient expressed their satisfaction about the support their whole family had received over a number of years they had been attending the practice.

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

We saw that staff followed the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. Telephone enquiries and calls for appointments were taken away from the reception area which helped keep patient information private.

The health centre registers patients with 'no fixed abode' and offers the health centre as a "care of" address. This ensured access to health care to a very vulnerable group, which is not available through other practices locally.

Care planning and involvement in decisions about care and treatment

Information from patients showed patients experienced being involved in planning and making decisions about their care and treatment and generally felt the practice did well in these areas. Patients also felt the GP was good at explaining treatment and results. This was also reflected in the comments received about the practice nurses and health care assistants. If a patient decided to decline treatment or a care plan this was listened to and acted upon.

Staff told us that translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

Patient/carer support to cope emotionally with care and treatment

The information from patients showed they were positive about the emotional support provided by the practice staff and told us that they found the staff to be supportive and very caring. This was reflected in comments from health and social care professionals who provided feedback about their observations of the service.

The practice told us they offered longer appointments for patients who needed them to aid communication. They also told us they always tried to check with patients that the gender of GP met their choices and they aimed to provide continuity of care by providing a named GP.

Notices in the patient waiting rooms and patient website also told patients how to access a number of support groups and organisations. The practice newsletter also provided details of local support groups and services. The practice had a focus on working with other organisations outside of the NHS to increase patient's awareness of additional sources of advice and support. Specifically a new GP commissioned service called Health Connections Mendip, an organisation that supported patients to maintain health and well-being, which had started having regular presence in the practice since April 2015. The newly developed Health Connections Mendip service which was partly facilitated by Glastonbury Health Centre and another

Good

Are services caring?

local medical practice, was developed to build patient confidence and self- reliance in managing their own conditions and use services available to them for support. So far the practice has signposted 17 patients directly to the support service which had included a number of patients with mental health needs. Patients were provided with one to one sessions for coaching to have the confidence to manage their own health and mental well-being.

The practice had developed ways of identifying patients who had additional needs and supporting them e.g. Practice weekly walking group to help patients who were seeking exercise strategies, had mental health issues or bereaved. Information to support health promotion was available.

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 patients' needs and the needs of the practice population were understood and systems were in place to address their identified needs. For example, we heard from a consultant psychiatrist and the manager of a mental health team about the support and responsiveness of the practice to provide care that was respectful of their patient's wishes. They told us they worked well together to provide individual support to each patient.

Glastonbury Health Centre was the only practice in the area that accommodated patients with substance misuse offering 'shared care' service with the Somerset Drug and Alcohol service.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request and this included patients requiring home visits.

There was a computerised system for obtaining repeat prescriptions and patients used a dedicated online request service, posted or placed their request either in a drop box in reception or outside the building.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out regular patient surveys and there was evidence that information from these was used to develop services provided by the practice, this included the planning for the new building the surgery is now based in.

Tackling inequity and promoting equality

The practice had recognised they needed to support people of different groups in the planning and delivery of its services. The PPG were actively seeking to recruit younger people to be involved and the practice was supporting them to look at using different methods, including media, to reach them. GPs and other staff were involved with providing support and information to vulnerable groups such as the travellers and homeless that visit the Glastonbury area.

The practice is located in purpose built premises (2012).The main patient areas of the practice were situated on the ground floor of the building. The two consulting rooms situated on the first floor were accessible by lift or stairs.

The patient waiting room, a reception desk and a patient health check area were to the front of the building. Consulting and treatment rooms lead off these areas. Administration, management and meeting rooms were located on the first floor of the building.

The patient waiting areas were large enough to accommodate patients with wheelchairs and prams and allowed easy access to the treatment and consultation rooms. Accessible toilet facilities were available and there was separate baby changing facilities. A patient shower was available on the first floor should it be required.

Access to the service

Glastonbury Health Centre had core hours of opening from 8.00am to 6.30pm every weekday; they remained open until 7.30pm on Wednesdays. The practice referred patients to another provider NHS 111, and then South West Ambulance Service for an Out of Hour's service to deal with any urgent patient needs when the practice was closed.

Information was available to patients about the opening times and appointments on the practice website, these were also available on display in the practice waiting areas and provided to patients when they registered with the practice. This information included how to arrange urgent appointments, home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, an answerphone message gave patients the telephone number they should ring for the Out of Hours service

Patients were satisfied with the appointments system. They confirmed that they could see a GP on the same day if they needed to. They also said they could see another GP if there was a wait to see the GP of their choice. Comments received from patients showed that patients in urgent need of treatment were able to either speak to a GP or attend 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. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person, the practice manager, who handled all complaints in the practice.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Information was available to help patients understand the complaints system. It was included in the practice information leaflet, on display in the patient areas and available on the practice website. The information contained details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately.

We looked at the information about the 17 complaints the practice had received in the 12 months from April 2014 to March 2015. The complaints ranged from a variety of issues, a patient not happy with a change in their planned care, communication, and attitude of staff. The complainant had been kept informed about the complaint investigation and the outcome. The practice had looked at how it could improve and avoid incidents recurring and patients raising similar complaints in the future. There was evidence that staff had put changes in place including training and changes in administration practices. Patients had the opportunity to make comments; a comments box was available in the practice reception. Patients also expressed their opinion about the service on NHS Choices. Each comment was responded to by the practice and learning and actions put in place to prevent recurrence. Equally compliments, a 'chocolate box' audit, was reviewed by the practice and patients were responded to and thanked for their feedback.

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 provide high quality safe, effective and person centred primary health care to the community of Glastonbury. Their prime objective was to maximise the health of the local population through prevention, education and intervention.

When we spoke with the GPs, practice nurses and members of administration, they all understood the vision and values of the practice and the aim of the practice team to achieve good outcomes for patients and the community.

Governance arrangements

The practice had a number of policies and procedures in place to govern how services were provided. These policies and procedures were available electronically, some in hard copy for easy access. There was a system to ensure that policies and procedures were reviewed and updated where required on an annual basis. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, medicines management and vaccines.

There was a leadership structure with named members of staff in lead roles. For example, named GPs were the leads for safeguarding children and adults. There was a lead GP for Clinical Governance. One GP was on the West Mendip GP Forum and previously were a member of the Clinical Commissioning Group. All of the members of staff we spoke with were clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The practice had carried out clinical audits which it used to monitor quality and had systems to identify where action should be taken.

The practice had arrangements for identifying, recording and managing risks. Risks were identified and managed effectively and action plans had been produced and implemented.

The practice partners and salaried GPs had a system of daily, weekly and monthly meetings for governance, business and to discuss patient's needs. Patients' who required more support were discussed with multidisciplinary teams. . Monthly meetings were held to monitor patients who were assessed and were identified as vulnerable or at risk, such as children who were of concern.

Leadership, openness and transparency

Practice staff met monthly to discuss the service delivery within their own peer groups. Important information was disseminated between these meetings should urgent issues arise. Staff told us that there was an open culture within the practice and they had the opportunity and were happy to raise issues at team meetings.

The practice employed a practice manager who oversaw the administration and management of the partnership. Their role included being responsible for human resource policies and procedures and their implementation. We reviewed a number of policies, such as those for aspects of health and safety found they were up to date and had the required information. We were told they were in the process of implementing a new resource for policies and procedures to ensure they kept them up to date and current to the changes in legislation and guidance. Staff we spoke with knew where to find these policies if required.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through patient surveys, compliments and complaints received. We looked at the results of the annual patient survey and saw that patients had highlighted a range of issues that they thought could be improved or what they did well. The practice had a virtual patient participation group (PPG) that had supported the practice to carry out annual surveys. We met and spoke with four representatives of the PPG who told us about their involvement with the practice and the plans they had for developing the relationship and support to the practice patients. They provided information of how the practice had listened and responded to the questions they raised and the feedback they had provided.

The practice had gathered feedback from staff through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management.

The practice had a whistleblowing policy which was available to all staff electronically on any computer within the practice. This enabled staff to raise concerns without fear of reprisal.

Are services well-led?

Good

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff confirmed that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training and that they were provided with opportunities to develop new skills and extend their roles.

We heard how the practice was a teaching practice and much valued the support they were able to provide to GP trainees and medical students. They told us they had found it a two way learning process, that prompted GPs at the practice to keep up to date and develop new skills and interests.

The practice had completed reviews of significant events and other incidents and shared information with staff at meetings to ensure the practice improved outcomes for patients.