Dr Denner & Partners

Quality Report

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

Ratings

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

Summary of findings

Contents

Overall summary

Dr Denner and Partners (also known as Essex House) was inspected on Wednesday 26 November 2014. This was a comprehensive inspection.

Essex House provides a service to approximately 9,200 patients in the Somerset town of Chard.

Essex House provides primary medical services to a diverse population age group and is situated in a town centre location.

There is a team of five GP partners, three males and two females. GP partners hold managerial and financial responsibility for running the business. In addition there were an additional salaried GP employed at the practice, four registered nurses, three health care assistants, a practice manager and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

We rated this practice as good.

Our key findings were as follows:

The service is safe. There are systems in place to address incidents, deal with complaints and protect adults, children and other vulnerable people who use the service. Significant events are recorded and shared with multi professional agencies and there is evidence that lessons are learned and systems changed so that patient care is improved.

The service is effective. There are systems in place to support the GPs and other clinical staff to improve clinical outcomes for patients. According to data from the Quality and Outcomes Framework (QOF), which is the annual reward and incentive programme detailing GP practice achievement results, outcomes for patients registered with this practice are equal to or above average for the locality. Patient care and treatment is considered in line with best practice national guidelines and staff are proactive in promoting good health. There were sufficient staff working at the practice and recruitment was in place to fill vacancies.

The service is caring. The practice is pro-active in obtaining as much information as possible about their

Summary of findings

patients which do or can affect their health and wellbeing. Staff know the practice patients well, are able to identify people in crisis and are professional and respectful when providing care and treatment.

The service is responsive. The practice plans its services to meet the diversity of its patients. There are good facilities available, adjustments are made to meet the needs of the patients and there is an effective appointment system in place which enables good access to the service.

The service is well led. The practice has a clear vision and set of values which are understood by staff and made known to patients. There is a clear leadership structure in place.

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

The provider should ensure that:

- Learning points from significant events should be circulated more consistently and effectively.
- Improvements to the repeat prescriptions of named medicines should be improved to ensure safety.

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 .

Patients we spoke with told us they felt safe, confident in the care they received and well cared for.

Staffing levels and skill mix were planned and reviewed so that patients received safe care and treatment at all times.

Recruitment procedures and checks were completed on permanent staff as required to help ensure that staff were suitable and competent. Risk assessments were performed, including when a decision had been made not to perform a disclosure and barring check (previously called a criminal records check) on administration staff.

Significant events and incidents were investigated systematically and formally. There were systems to ensure that learning and actions had been taken following such investigations. However, evidence did not always show that learning points had been communicated consistently and effectively to all members of the team.

Staff were aware of their responsibilities in regard to safeguarding and the Mental Capacity Act (2005) (MCA). MCA training had been provided for GPs and nursing staff. There were safeguarding policies and procedures in place that helped identify and protect children and adults who used the practice from the risk of abuse.

There were arrangements for the efficient management of medicines within the practice, although the repeat prescription process for some medicines did not always demonstrate a robust and safe system.

The practice was clean, tidy and hygienic. Arrangements were in place that ensured the cleanliness of the practice was consistently maintained. There were systems in place for the retention and disposal of clinical waste.

Are services effective?

Good

The practice is rated as good for providing effective services.

Systems were in place to help ensure that all GPs and nursing staff were up-to-date with both National Institute for Health and Care Excellence (NICE) guidelines and other locally agreed guidelines. Evidence confirmed that these guidelines were influencing and improving practice and outcomes for patients.

Summary of findings

The practice was using the national Quality Outcome Framework (QOF- a national performance measurement tool) scheme. Data providedby the practice showed that the practice was performing equally when compared to neighbouring practices in the Clinical Commissioning Group (CCG).

Patient's needs were assessed and care was planned and delivered in line with current legislation. This included assessment of capacity to give informed consent to treatment and the promotion of good health. Staff had received training appropriate and in addition to their roles. Effective multidisciplinary working was evidenced.

Regular completed audits were performed of patient outcomes which showed a consistent level of care and effective outcomes for patients. We saw evidence that audit and performance was driving improvement for patient outcomes.

There was a systematic induction and training programme in place with a culture of promoting education to benefit patient care and increase the scope of practice for staff.

The practice worked together efficiently with other services to deliver effective care and treatment.

Are services caring?

Good

The practice is rated as good for providing caring services.

Feedback from patients about their care and treatment was consistently positive. The 27 comment cards we received and survey data from March 2013 reflected this feedback. The GPs described themselves as a traditional family GP service. Patients agreed with this and said they trusted the GPs and knew them well.

We observed a person centred culture and found strong evidence that staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles to achieving this. We found many positive examples to demonstrate how people's choices and preferences were valued and acted on. Accessible information was provided to help patients understand the care available to them. This included health information being provided in Portuguese and Polish to meet the needs of the local community.

Patients said they were treated with compassion, dignity and respect and they were involved in care and treatment decisions.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Summary of findings

The practice was supported by an active and diverse Patient Participation Group (PPG). The practice and PPG had responded to feedback from patients that information in the waiting room was confusing. This had led to the introduction of themed notice boards where patients could get all the information they needed in one place.

We found the practice had responded to patient feedback. For example, feedback from the patient survey had resulted in Saturday morning appointments and evening appointments being offered once a week.

Patients said they could get an appointment easily in advance or with a GP on the same day.

The practice reviewed secure service improvements where these were identified. For example, a scheme to prevent unnecessary hospital admissions.

There was an accessible complaints system with evidence that the practice responded quickly to issues raised. There was evidence of shared learning, by staff and other stakeholders, from complaints.

Are services well-led?

Good

The practice is rated as good for well led.

It had a clear vision and strategy. There had been staff shortages over recent months but staff had supported each other and morale remained high.

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. There were systems in place to monitor and improve quality and identify risk. The process of clinical governance was being improved with the introduction of whole team meetings to discuss significant events so learning could be shared with the whole team.

The practice learnt from events and complaints. The patient participation group (PPG) was active and prompted change. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

The practice is rated as good for the care of older people.

Information from Public Health England showed that the practice's patient population had a relatively higher proportion of older people compared to the county and the England average.

The practice operated a personal list system. This meant all patients aged 75 and over had their own allocated GP but were able to choose an alternative if they wished.

Pneumococcal vaccinations and shingles vaccinations were provided for older people, with GPs undertaking home visits for those patients unable to come to the surgery. The practice worked with the community nurse team to provide seamless care for housebound patients.

The practice did not provide specific older person clinics. Treatment was organised around the individual patient and any specific condition or need they had.

The practice worked with the community matron to identify patients at greater risk of admission or deterioration and used a 'Tele health' programme to provide additional support for those patients at home. Tele health is the remote exchange of data between a patient at home and their clinician(s) to assist in diagnosis and monitoring. Among other things it comprises of fixed or mobile home units to measure and monitor temperatures, blood pressure and other vital signs parameters which may instigate early intervention of any deterioration.

The practice identified older patients with life- limiting conditions and co-ordinated a multi-disciplinary team (MDT) for the planning and delivery of palliative care for people approaching the end of life. The practice reviewed their palliative care register every six weeks with the community nurses and local hospice liaison nurse. The practice also proactively reviewed patients who are approaching the palliative stage of their life so the team can meet the needs of vulnerable patients.

The practice website included a number of links to organisations that provide support and advice regarding conditions that affect older people.

The GPs worked to avoid unnecessary admissions to hospital and worked with the local federation complex care GP who visited patients in residential homes who were at high risk of hospital

admission. The GPs had produced care plans for patients they considered at the highest risk of admission. This was part of the enhanced service they offered to avoid patients being admitted to hospital unnecessarily.

The practice had one level for easy access with a ramp from the old building to the newer extension. Chairs in the waiting room had been changed to include some with arm rests to assist patients to stand. High back chairs were available for patients with greater mobility problems. The patient call system had been upgraded to include an anonymised audible call as well as larger visual display when calling patients.

The practice had worked with the patient participation group (PPG) to help patients find information more easily at the surgery with the introduction of themed notice boards for certain conditions, for example, respiratory diseases, heart disease, diabetes, stroke and dementia.

The practice had a carers champion and provided support and information for patients who were carers.

People with long term conditions

Good

A number of practices in Somerset had moved away from contracting to the Quality and Outcomes Framework (QOF). QOF is a national performance measurement tool. However, this practice had made a decision to continue with this monitoring. The practice used the QOF to identify and support patients with long term conditions to ensure their needs were monitored and gave assurances that they were providing care to set practice standards and working within NICE Guidelines. Whilst the new quality system was being fully introduced, the practice had continued to use the QOF system to collect data to ensure themselves they were performing well.

Patients with long term conditions had personal care plans in place. Respiratory and diabetic clinics were run by practice nurses with specialist qualifications. The nurses attended educational updates to make sure their lead role, knowledge and skills were kept up to date.

The practice provided clinics for asthma and chronic lung disorders (COPD) including using spirometry, a lung capacity test, as part of its service to assess the evolving needs of this group of patients.

The practice promoted independence and self-care for patients with long term conditions. Patients who were suitable and wanted to improve their management were encouraged to join the Telehealth home monitoring scheme. For those patients requiring more input, referrals were made to the intermediate COPD respiratory service.

Summary of findings

All newly diagnosed diabetic patients were seen by specialist diabetic nurses who provided diabetic monitoring, health education and life style guidance. Patients were referred to the local education programme for newly diagnosed diabetics and were reviewed every six months by practice nurses. The check included a comprehensive diabetic check including a monofilament foot and pulse examination to check for vascular disease and encouragement to attend retinal screening.

The computer system contained health promotion prompts so opportunistic screening could take place regardless of for the reason for the patient's attendance.

The practice offered a compression bandaging service and doppler assessments to assess patient's arterial blood vessels.

Weight management clinics were run by the nursing team who had received specialist training. These appointments were offered later in the day to support patients who worked or relied on family members to bring them to the surgery. The practice also worked with a dietician twice a month to see patients with more complex dietary needs.

All patients with complex needs who were in receipt of a care plan were contacted by the surgery following any admission or attendance at A&E and home visits were undertaken if required to ensure medicine reviews were performed.

Enhanced monitoring for certain medicines was done at the practice to ensure drugs were safe and effective and to monitor any potential side effects. Patients who did not attend for screening were contacted and recalled by the practice.

The practice sent 'special messages' to the out of hours providers of patients with complex needs so the out of hours service was aware of their needs. For patients at the end of their life the practice used a computerised clinical patient management system to provide continuity by automatically sending full consultation details to the out of hours provider allowing patients to have a seamless experience.

Families, children and young people

Good

The practice had a separate waiting area for children. There were toys available which were cleaned on a regular basis.

The practice held weekly baby and child immunisation clinics and sent letters of invitation to all parents and carers.

Summary of findings

After three attempts by child health visitor to recall non-attenders for immunisations, patients were reviewed by the GP and contacted by the surgery. If there were any concerns regarding the reasons for non- attendance these were raised with the Health Visitor.

Ante-natal care was provided at local children's centres by the community midwives. The midwives worked with the GPs and practice team. The practice team met every six weeks with the health visitor team, midwife and school nurse to discuss any vulnerable babies, children or families. These meetings and process had been highlighted as best practice by the clinical commissioning group safeguarding team.

Women and young people had access to a full range of contraception and sexual health services, including coil fitting, contraceptive implants, chlamydia testing and cervical screening. There was a side room in the practice for women to use when breastfeeding.

Appropriate systems were in place to help safeguard children or young people who may be vulnerable or at risk of abuse. All staff had received training on safeguarding children and young people.

The practice provide following work with local schools identifying issues some young people have in understanding and accessing health care.

Working age people (including those recently retired and students)

Good

The practice offered advanced booking for appointments. Saturday appointments were also available, plus Wednesdays and Thursday evening appointments.

NHS health checks, weight checks, healthy living advice, blood pressure checks, new patient checks and smoking cessation appointments were offered weekly between 5.00 - 7.00pm to help patients who worked to access healthcare screening.

There was an online appointment booking system and prescription request via the practice website so patients could make their requests at any time that suited them.

The practice had a Patient Participation Group (PPG) with a small committee which met every two months. There is also a large virtual group with 90 members. Some of these members were patients who are of working age, recently retired. The practice communicates with these patients electronically. The practice had approached the local sixth form college to invite students to attend the group.

Summary of findings

The practice offered travel advice and vaccinations. The surgery was a registered yellow fever vaccination centre. Nurses who provided this service had received specialist training

Patients who received repeat medicines were able to collect their prescriptions at a pharmacy of their choice. The practice also worked with local pharmacy repeat ordering schemes.

The practice offered services including minor surgery, joint injections, patient anti-coagulation monitoring and cryotherapy to reduce the number of hospital attendances patients make.

People whose circumstances may make them vulnerable

Good

The practice had a large Polish and Portuguese population. The practice had access to a translation service but said that patients often chose to attend consultations with family members to help translate. The practice displayed literature translated into Polish and Portuguese.

Patients with learning disabilities were offered a health check every year during which their long term care plans were discussed with the patient and their carer if appropriate. Patients who found it stressful to come to the surgery were visited in their own home.

Practice staff encouraged patients with alcohol addictions to self-refer to an alcohol service for support and treatment.

People experiencing poor mental health (including people with dementia)

Good

The practice had a mental health lead GP who had a long standing interest in mental health problems. A register at the practice identified patients who had mental illness or mental health problems.

The practice had a talking therapy service that patients could self -refer to. Patients who had depression were seen regularly and were followed up if they did not attend appointments.

The practice used QOF to ensure mental health medicine reviews were conducted to ensure patients received appropriate medicines and care plans were in place. Blood tests are regularly performed on patients receiving certain mental health medicines.

The practice worked with the community mental health team and referred patients for urgent intervention when required. The GPs referred patients to the community mental health team for assessment and treatment for older patients who suffer with mental health issues or needed assessments for dementia. The practice

Summary of findings

participated in the Facilitating Early Diagnosis of Dementia service (a charity led research project) and had created an alert message on the medical records for those patients with an increased risk of dementia.

The practice staff had an understanding of the Mental Capacity Act (2005) and had attended training sessions at the surgery.

Summary of findings

What people who use the service say

We spoke with eleven patients during our inspection and three representatives from the patient participation group (PPG).

The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We collected twenty seven comment cards, all of which contained positive comments. There were no negative comments.

Comment cards were detailed and stated that patients appreciated the service provided, the caring attitude of the staff and the staff who took time to listen effectively. There were many comments praising GPs, nurses and the reception team. Comments also highlighted a confidence in the advice and medical knowledge and a feeling of not being rushed.

These findings were reflected during our conversations with patients and discussion with the PPG members. The feedback from patients was overwhelmingly positive. Patients told us about their experiences of care and praised the level of care and support they consistently received at the practice. Patients said they were happy, very satisfied and said they had no complaints and received good treatment. Patients told us that the GPs and nursing staff were excellent. Patients also commented on the good choice of locum GPs.

Patients were happy with the appointment system. We were told patients could either book routine appointments in advance or make an appointment on the day. We spoke with one patient who had made their 10.30 appointment at 9am that morning. They told us the receptionists tried to fit them in where possible.

Patients knew how to contact services out of hours and said information at the practice was good. Patients knew how to make a complaint. None of the patients we spoke with had done so but all agreed that they felt any problems would be managed well. Other patients told us they had no concerns or complaints and could not imagine needing to complain.

Patients were satisfied with the facilities at the practice and commented on the building always being clean and tidy. Patients told us staff used gloves and aprons where needed and washed their hands before treatment was provided.

Patients found it easy to get repeat prescriptions and said they thought the information provided and the practice website were good.

Areas for improvement

Action the service SHOULD take to improve

- Learning points from significant events should be circulated more consistently and effectively.
- Improvements to the repeat prescriptions of named medicines should be improved to ensure safety.

Dr Denner & Partners

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a GP specialist advisor, a practice manager specialist advisor and a practice nurse specialist advisor.

Background to Dr Denner & Partners

Essex House provides a primary medical service to approximately 9,200 patients in the Somerset town of Chard. The practice is situated in the town centre.

There is a team of five GP partners, three males and two females. GP partners hold managerial and financial responsibility for running the business. In addition there was an additional salaried GP employed at the practice, four registered nurses, three health care assistants, a practice manager, and additional administrative and reception staff.

Patients using the practice also have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, speech therapists, counsellors, podiatrists and midwives.

The practice is open between the hours of 8am and 6.30pm with appointments available from 08.30. Extended hours include GP appointments until 7.30pm each Wednesday and Nurse/healthcare appointments until 7.20pm on Thursdays. The practice is also open on alternate Saturdays between 8am and 10.30am.

The practice had opted out of providing out-of-hours services to their own patients and refer them to the NHS 111 service. The practice website also signposts patients to the local Walk in Centre which is open 8am to 8pm seven days a week.

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme.

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, 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

Before conducting our announced inspection of Essex House, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England and the local Somerset Clinical Commissioning Group (CCG).

Detailed findings

We requested information and documentation from the provider which was made available to us either before, during or 48 hours after the inspection.

We carried out our announced visit on Wednesday 26 November 2014. We spoke with eleven patients and 12 members of staff at the practice during our inspection and collected 27 patient responses from our comments box which had been displayed in the waiting room. We obtained information from and spoke with the practice manager, GPs, receptionists/clerical staff, and nursing staff. We observed how the practice was run and looked at the facilities and the information available to patients. We also spoke with three representatives from the patient participation group (PPG).

We looked at documentation that related to the management of the practice and anonymised patient records in order to see the processes followed by the staff.

We observed staff interactions with other staff and with patients and made observations throughout the internal and external areas of the building.

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

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

We also looked at how well services are provided for specific groups of people and what good care looks like for them. These 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)

Good

Are services safe?

Our findings

Safe track record

The practice 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 to were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example, practice staff had been informed there had been an alleged delay in diagnosis of a patient's condition. This was discussed at the formal significant event meeting and although no cause had been identified, awareness raised of the particular condition was shared. The patient had then been informed of the process.

We reviewed safety records, incident reports and minutes of meetings where these were discussed for the last two years. This showed the practice had managed these consistently over time and so could show evidence of a safe track record.

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. There were records of significant events that had occurred during the last year and we were able to review these. Significant events were discussed at the daily informal morning meeting or as part of a structured six weekly meeting where significant events and complaints were part of a standard agenda. There was evidence that the practice had learned from these events. However, there was not always evidence to demonstrate that learning had been consistently shared with all relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff explained the system they used to manage and monitor incidents. We tracked three incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result. For example, practice staff had recognised communication about the risks of insertion of contraceptive coils could be improved. This had led to improved information given to patients.

National patient safety alerts were disseminated verbally and by email to practice staff. Staff told us alerts were discussed to ensure all staff were aware of any that were relevant to the practice and where they needed to take action.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We looked at training records which showed that all staff had received relevant role specific training on safeguarding. 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 displayed on a flow chart were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained and could demonstrate they had the necessary advanced level three training to enable them to fulfil this role. All staff we spoke to were aware who these leads were and who to speak to in the practice if they had a safeguarding concern.

Practice staff said communication between health visitors and the practice was good and any concerns were followed up. For example, if a child failed to attend routine appointments, looked unkempt or was losing weight the GP could raise a concern for the health visitor to follow up.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments. For example children subject to child protection plans and patients with mental health issues.

There was a chaperone policy, which was displayed in consulting rooms. Selected staff had been trained to be a chaperone and understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination.

Medicines management

Good

Are services safe?

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 clear policy for ensuring that medicines were kept at the required temperatures, which included inaccessible plug sockets.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations. There was a robust system in place to monitor the medicines and expiry dates kept in the GPs grab bag.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data. For example, 93% of patients who were taking more than four types of medicine were reviewed annually or more often to ensure they were on the correct medicine and dosage.

The nurses and the health care assistant administered vaccines using patient group directives and patient specific directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of documents and evidence that nurses and the health care assistant had received appropriate training to administer vaccines. The nurses had also received appropriate training to administer travel vaccinations and give travel advice.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times. However, we saw that the process for repeat prescriptions was not always robust. For example, we saw two examples where repeat medicines were processed despite the patient needing to have blood levels checked.

The practice did not hold any controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse).

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

Cleanliness and infection control

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

The practice had a lead for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. The lead nurse had performed an infection control audit in September 2014 and had made changes including updating policies and procedures and providing hand washing training for staff. All staff received induction training about infection control specific to their role.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use. Staff were able to describe how they would use these to comply with the practice's infection control policy. There were also policies for needle stick injuries and for Ebola.

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.

Equipment

Staff we spoke with told us they were provided with 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 of March 2014.

Staffing and recruitment

Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff.

Good

Are services safe?

Staff told us that there had been staff shortages in recent months and explained 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. Staff told us about the arrangement in place to cover each other's annual leave. For example, how blood tests were checked by the GPs in the absence of a GP.

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. Staff explained this had been a challenge in recent months with the identified staff shortages.

Monitoring safety and responding to risk

The practice had systems, processes and policies in place to manage and monitor risks to patients, staff and visitors to the practice. These included regular checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy which had been updated. Health and safety information was displayed for staff to see. There had been a fire safety fire risk assessment performed in October 2014. The practice were working through the actions to be followed up including performing staff fire drills which had last been performed in 2012.

The practice had a business continuity plan in place which had contact details of organisations and companies to contact in the event of a disaster.

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 to attempt to restart a person's heart in an emergency). When we asked members of staff, they all knew the location of this equipment and records confirmed that it was checked regularly.

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

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. Patients were pleased with the care, treatment and advice they received. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The GPs told us they lead in specialist clinical areas such as diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were very open about asking for and providing colleagues with advice and support. For example, GPs told us this supported all staff to continually review and discuss new best practice guidelines for the management of respiratory disorders. The nursing team had experience in managing long term conditions and had received additional training and education on conditions including diabetes and asthma.

The practice had an option to opt out of the national quality monitoring scheme but had decided to remain with the QOF scheme (a quality monitoring scheme used by GPs) as a way of monitoring quality. The data were saw showed they were comparable with other practices in the area and within England.

The practice completed audits to ensure patients were receiving appropriate care and treatment. For example, an audit was conducted to look at ways of improving the detection of patients with abnormal heart rates. Other examples included auditing medication usage to ensure it was appropriate and the most cost effective treatment for patients. Both audits had been completed and repeated to show a full audit cycle.

National data and practice computer systems showed that the practice was in line with referral rates to secondary and other community care services for all conditions. The GPs used national standards for the referral of suspected cancers within two weeks. We saw systems used by administration staff to show how routine and urgent referrals were made.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race were not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management. The information staff collected was then collated by the practice manager and deputy practice manager to support the practice to carry out clinical audits.

The practice showed us three clinical audits that had been undertaken in the last year. All of these were completed audits where the practice was able to demonstrate the changes resulting since the initial audit. For example, the GPs told us clinical audits were linked to medicines management information, safety alerts or as a result of information from the previously used quality and outcomes framework (QOF). QOF is a national performance measurement tool.

We saw an audit which looked at how GPs were monitoring patients on specific medicines with a heart condition. Following the audit, the GPs carried out medication reviews for patients who were prescribed these medicines and altered their prescribing practice, in line with the guidelines. GPs maintained records showing how they had evaluated the service, documented the success of any changes and set a date to repeat the audit.

The team were sharing clinical audits, learning from significant events, clinical supervision and holding staff meetings to review the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice and said there was an eagerness to learn. There was an expectation that all clinical staff should undertake audit as part of their revalidation or continued professional development.

Good

Are services effective?

(for example, treatment is effective)

The practice implemented the gold standards framework for end of life care. It kept a register of patients who were receiving palliative care and had regular internal as well as monthly multidisciplinary meetings to discuss the care and support needs of these patients and their families.

The practice also participated in local schemes run by the Somerset Clinical Commissioning Group (CCG). This included GPs working closely with the local hospital in Chard and working with the multidisciplinary health and social care team to help prevent unnecessary hospital admissions.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with annual basic life support and safeguarding training. Staff were clear about what training had been decided as mandatory by the practice. There was a system in place to show what staff had received which training.

We noted a good skill mix among the doctors. 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 NHS England can the GP continue to practise and remain on the performers list with the General Medical Council).

All staff received annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was proactive in providing training and funding for relevant courses.

Practice nurses were expected to perform defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, on administration of vaccines, cervical cytology and travel advice. Those with extended roles such as diabetes and asthma were also able to demonstrate that they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet people's needs and manage complex cases. 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 communications with other care providers on the day they were received. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances within the last year of any results or discharge summaries that were not followed up appropriately.

The practice had a process in place to follow up patients discharged from hospital. Staff said this system worked well and that the community matron or GP would visit vulnerable patients.

The practice held multidisciplinary team meetings monthly to discuss the needs of complex patients. For example a monthly end of life/palliative care meeting was held and a monthly multidisciplinary meeting was held to discuss vulnerable patients. The GPs explained that further specific discussions were held with other health care professionals where required.

The staff at the practice worked with other organisations in the community. One of the GPs worked with the clinical commissioning group at the local community hospital.

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. Electronic systems were also in place for making referrals, and the practice used the Choose and Book system. (The Choose and Book system enables patients to choose which hospital they will be seen in and to book their own outpatient appointments in discussion with their chosen hospital). Staff reported that this system was easy to use and showed us the back-up system to ensure the appointments had been arranged.

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, and commented positively about the system's safety and ease of use. 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), although not all staff had received training in this subject but were aware of their duties in fulfilling it. The nursing staff understood the key principles and said they would refer to the GPs. The GPs shared examples of when they had implemented it in their practice.

Patients with a learning disability and those with dementia were supported to make decisions through the use of care plans, which they were involved in agreeing. These care plans were reviewed annually (or more frequently if changes in clinical circumstances dictated it) and had a section stating the patient's preferences for treatment and decisions.

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures. The consent was documented in the electronic patient notes with a record of the relevant risks, benefits and complications of the procedure. An audit had been performed on consent which showed that 95% had a written consent recorded for the minor surgery procedures. The remaining consents for joint injections where verbal consent was recorded in the patient record.

Health promotion and prevention

It was practice policy to offer a health check with the health care assistant / practice nurse to all new patients registering with the practice. The GP summarised all patient records and was informed of all health concerns detected. These were followed up in a timely way. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, they offered chlamydia screening to patients aged 18-25 and offered smoking cessation advice to people who smoke.

The practice also offered NHS health checks to all its patients aged 40-75. Practice data showed that 56% of patients in this age group took up the offer of the health check.

The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice kept a register of all patients with a learning disability. We saw that 76.5% of patients with learning disabilities had received a health check and review in the last year.

The practice's performance for cervical smear uptake was 82% which was comparable to other practices in the CCG area. There was a policy to offer written reminders for patients who did not attend for cervical smears and the practice audited patients who did not attend annually. The nursing team were responsible for following up patients who did not attend screening.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Practice data showed that 90% of parents and carers had chosen to have their child immunised.

There was a range of leaflets and information documents available for patients within the practice and on the website. These included information on family health, travel advice, long term conditions and minor illnesses. These links were simple to locate. There was a medical library were patients could borrow books and DVDs on a wide range of medical and healthcare related topics.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the most recent patient survey in March 2013. This showed that 77% of respondents would recommend the practice to their friends or family. 77% of respondents said the GP listens to patients and 88% said the GP was excellent or very good at involving patients in decisions about their care.

Patients completed CQC comment cards to tell us what they thought about the practice. We received twenty seven completed cards, all of which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with 11 patients on the day of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by a wall which helped keep patient information private. A system was in place to allow only one patient at a time to approach the reception desk. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. The call system was anonymous. Patients were issued with a number and waited for the number to be called.

Care planning and involvement in decisions about care and treatment

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

Staff told us that 13% of all patients did not have English recorded as their first language. Translation services were available for these patients. We saw notices in the office areas informing patients this service was available. Staff explained that a couple of workplaces in the town employ people from other parts of Europe who had become patients. As a result posters in Polish and Portuguese had been introduced advertising services at the practice. Staff said having the translation service was reassuring but not used yet as patients had arrived with a good command of the English language.

Patient/carer support to cope emotionally with care and treatment

Patients were positive about the emotional support provided by the practice staff and said they had received help to access support services to help them manage their treatment and care when it had been needed. The patient comment cards we received were also consistent with this feedback. For example, these highlighted that staff responded compassionately when they needed help and provided support when required.

Notices in the patient waiting room and patient website also told people how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. Carer checks and information leaflets were offered.

Staff told us that if families had suffered bereavement they were sent a card from the practice and the patient's usual GP provided support. There were posters and leaflets offering advice on how to find a support service.

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 generally responsive to patients needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the patient survey had highlighted a need for longer appointments for more complex conditions. This had been discussed with the GPs and a longer appointment introduced.

The patient participation group (PPG) chair person told us they had been a group for approximately two years and had approximately nine members. They told us the practice manager always attended and GPs attended when they could. The PPG told us they had been involved in improving the services for patients with disabilities and introducing the Saturday appointments.

The PPG said the management at the practice had been responsive to suggestions made by the group, were approachable and swift to take action when it was identified. For example, notice boards had been organised and the patient survey was influenced by the PPG.

Tackling inequity and promoting equality

Staff were aware of equality and diversity issues and said they had access to training.

The premises and services had been adapted to meet the needs of people with disabilities. For example there were ramps and grab rails around the building and accessible toilet facilities.

The patient areas at the practice were arranged on one level. The practice had open spaces in the waiting room which provided turning circles for patients with mobility scooters. Corridors and doors were wide making the practice easier to get around which helped to maintain patients independence.

We saw that the waiting area was large enough to accommodate patients with prams and allowed for easy access to the treatment and consultation rooms. There were quiet areas for breast feeding mothers and baby changing facilities available.

Access to the service

The practice was open between the hours of 8am and 6.30pm with appointments available from 08.30. Extended hours included GP appointments until 7.30pm each Wednesday and nurse or healthcare assistant appointments until 7.20pm on Thursdays. The practice also opened on alternate Saturdays between 08.00am and 10.30am.

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

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns and had a clear policy for staff to follow. This policy was 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.

Information was available to help patients understand the complaints system. Patients we spoke with were aware of the process to follow if they wished to make a complaint. None of the patients we spoke with had felt the need to make a complaint.

We looked at the nine complaints received in the last 12 months and found three related to waiting times. The practice manager had used the complaint summary to look at trends. We saw that all complaints had been satisfactorily handled and dealt with in a timely way. We saw evidence of learning and changes in systems, policies and processes as a result of complaints. For example, the complaints and feedback from patient survey had resulted in patients being able to book extended appointments for complex issues.

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. This was reviewed during the regular partners meetings. There was a patient charter available which stated what patients could expect at the practice. This included being treated with courtesy and respect and being able to have an urgent appointment on the same day.

Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. We were told there had been social events in the past year to boost morale and team working. Staff said that even though there had been staff shortages the team working was still good and the vision and values were still current.

Governance arrangements

The practice had a number of policies and procedures in place to govern activity and these were available to staff. We looked at the complaints, safeguarding adult and child policies and whistleblowing policies and saw these had been reviewed in the last year.

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

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice and the new data being collected showed it was performing in line with national standards.

The practice had an ongoing programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We looked at three examples of clinical audit which followed good practice guidelines for audit. For example, the practice measured the care and services provided implemented changes in practice where necessary and re audited to make sure care and treatment was still appropriate.

The practice manager had a system in place for identifying, recording and managing risks. There had been a fire safety fire risk assessment completed in October 2014. The practice were working through the actions to be followed up including conducting fire drills for staff , these had last been performed in 2012.

The GPs met daily and held more formal regular partners meetings where complaints, significant events and incidents were discussed along with day to day events. The records for these events showed the action that took place, although evidence of learning from these events was not always clear or consistent.

Leadership, openness and transparency

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 manager was responsible for human resource policies and procedures. We reviewed a number of policies, for example, recruitment procedures and induction process which were in place to support staff. Each member of staff was issued with a staff handbook which explained employment procedures and expectations.

Seeking and acting on feedback from patients, public and staff

The practice had gathered feedback from patients through a patient survey in March 2014. The survey found that most patients felt that doctors and nurses gave them enough time, asked about symptoms, listened well, and explained tests and treatments. The majority of patients also said the GPs involved them in their care, treated them with care and concern and took their problems seriously. The survey highlighted three areas of concern. These included a request for additional disabled parking space, poor attitude of staff and a request to extend some appointment times to reduce waiting times. We saw evidence that all three areas had been addressed.

The practice had a PPG which had nine members. The PPG included representatives from two of the population groups including older people and patients with long term conditions. The PPG said the practice manager had been approachable and open to suggestions. The PPG were

Are services well-led?

Good

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

working with the practice manger to attract more members from other patient groups and had been into a local sixth form college to seek new members. To date this had been unsuccessful.

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

Management lead through learning and improvement

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was committed to NHS workforce planning. They had employed an apprentice on the administration team who was now fully employed and working towards a medical secretary qualification.