

# Somerton House Surgery

## 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?

Requires improvement 

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 Somerton House Surgery on 20 October 2016. Overall the practice is rated as good with the safe domain requiring improvement.

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

- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. All opportunities for learning from internal and external incidents were maximised.
- Risks to patients were assessed and well managed. We saw evidence of monitoring of infection control and fire safety.
- Staff assessed patients' needs and delivered care in line with current evidence based guidance. Staff had been trained to provide them with the skills, knowledge and experience to deliver effective care and treatment. However, we found some gaps in the staff training and recruitment checks and records.
- 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 within the practice but there was no information for patients to view on the practice website. Improvements were made to the quality of care as a result of complaints and concerns.
- Results from the national GP patient survey showed patients were treated with compassion, dignity and respect and were involved in their care and decisions about their treatment.
- Feedback from patients about their care was consistently positive. Patients told us that staff went the extra mile and the care that they received exceeded their expectations.
- The practice had strong and visible clinical and managerial leadership and governance arrangements; and staff felt supported by management and we saw evidence of effective arrangements for communication, including a monthly whole practice meeting.

# Summary of findings

- Patients we spoke with said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice was aware of the requirements of the duty of candour.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure that they meet patients' needs. For example, monthly multi-disciplinary meetings were held and we saw evidence of effective liaison with residential and nursing homes.

The areas where the provider must make improvement are:

- Ensure procedures for effective staff recruitment are fully implemented and records are complete so that

only staff who meet the requirements of the regulations are employed. For example, ensuring all staff have records of appropriate checks, including written references and a Disclosure and Barring Service (DBS) check in place before employment.

The areas where the provider should make improvement are:

- Review systems for monitoring training to ensure all staff receive relevant, up to date training and this is recorded, including training in safeguarding children and infection prevention and control.
- Review arrangements to ensure patients can access information on how to complain, including via the practice website.

**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 requires improvement for providing safe services.

- There was an effective system in place for reporting and recording significant events
- Lessons were shared to make sure action was taken to improve safety in the practice.
- When things went wrong patients were informed as soon as practicable, received reasonable support, truthful information, and a written apology. They were told about any actions to improve processes to prevent the same thing happening again.
- The practice had clearly defined systems, processes and practices to keep patients safe and safeguarded from abuse. However, there were some gaps in the training records for some staff, for example in safeguarding children and infection control. We spoke to the practice who, within 48 hours of the inspection, provided evidence of up to date training.
- Risks to patients were assessed and managed. However, the practice must review the arrangements for recruitment checks and records to ensure procedures are fully implemented.

Requires improvement



### Are services effective?

The practice is rated as good for providing effective services.

- Data from the Quality and Outcomes Framework (QOF) showed patient outcomes were at or above average compared to the national average.
- Staff assessed needs and delivered care in line with current evidence based guidance.
- Clinical audits demonstrated quality improvement.
- Staff had the skills, knowledge and experience to deliver effective care and treatment.
- There was evidence of appraisals and personal development plans for all staff.
- Staff worked with other health care professionals to understand and meet the range and complexity of patients' needs.
- End of life care was delivered in a coordinated way.
- We saw evidence that the practice used innovative and proactive methods to improve patient outcomes. For example,

Good



# Summary of findings

the practice had invested in Doppler machine (used to check blood circulation) which resulted in benefits to patients and staff including shorter appointment times, quicker assessment and more rapid referral to specialists where appropriate.

## Are services caring?

The practice is rated as good for providing caring services.

- Data from the national GP patient survey showed patients rated the practice higher than others for several aspects of care.
- Patients said they were treated with compassion, dignity and respect and they were involved in decisions about their care and treatment.
- Information for patients about the services available was easy to understand and accessible.
- We saw staff treated patients with kindness and respect, and maintained patient and information confidentiality.

Good



## Are services responsive to people's needs?

The practice is rated as good for providing responsive services.

- The practice understood its population profile and had used this understanding to meet the needs of its population. For example, there were longer appointments available for patients with learning disabilities.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions, including patients with a condition other than cancer and patients with dementia.
- Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- Information about how to complain was available within the practice. However, patients were unable to access it through their practice website. Evidence showed 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.

Good



# Summary of findings

- The practice had a clear vision and strategy to deliver high quality care and promote good outcomes for patients. Staff were clear about the vision and their responsibilities in relation to it.
- There was a clear leadership structure and staff felt supported by management. The practice had policies and procedures to govern activity and held regular governance meetings.
- An overarching governance framework supported the delivery of the strategy and good quality care. This included arrangements to monitor and improve quality and identify risk. However, we found some gaps in the implementation of arrangements for recruitment and training records. We spoke to the practice who, within 48 hours of the inspection, provided evidence that corrective action had been taken.
- Staff had received inductions, annual performance reviews and attended staff meetings and training opportunities.
- The practice was aware of and complied with the requirements of the duty of candour. The partners encouraged a culture of openness and honesty. The practice had systems for notifiable safety incidents and ensured this information was shared with staff to ensure appropriate action was taken.
- The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group had actively strived to improve the service by raising funds to improve outcomes for patients. For example, they had bought six new blood pressure monitors for patients to use at home and a Doppler machine, which improved patient access to quicker and more effective treatment.
- GPs who were skilled in specialist areas used their expertise to offer additional services to patients.

# Summary of findings

## The six population groups and what we found

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

### Older people

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

- Staff were able to recognise the signs of abuse in older patients and knew how to escalate any concerns.
- The practice offered proactive, personalised care to meet the needs of the older patients in its population.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs.
- The practice identified at an early stage older patients who may be approaching the end of life. They involved older patients in planning and making decisions about their care, including their end of life care.
- The practice followed up on older patients discharged from hospital and ensured that their care plans were updated to reflect any extra needs.
- Where older patients had complex needs, the practice shared summary care records with local care services, including the community care teams, such as the community and palliative care nurses.
- Older patients were provided with health promotional advice and support to help them to maintain their health and independence for as long as possible.
- The practice had two GPs who led the monitoring of patients who lived in residential or nursing homes. They had regular liaison with the homes, for example, by attending the nursing homes for weekly ward rounds, in addition to urgent home visits. They also attended a quarterly meeting, with two other practices, for one large nursing home to enhance the coordination of care.

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 long-term disease management and patients at risk of hospital admission were identified as a priority.
- The percentage of patients on the diabetes register who had had a foot examination in the last 12 months was 93% which was better than the clinical commissioning group (CCG) average of 92% and national average of 88%.

Good



# Summary of findings

- The practice proactively identified patients at risk of developing long-term conditions and took action to monitor their health and help them improve their lifestyle.
- The practice followed up on patients with long-term conditions discharged from hospital and ensured that their care plans were updated to reflect any additional needs.
- There were emergency processes for patients with long-term conditions who experienced a sudden deterioration in health.
- Longer appointments and home visits were available when needed.
- All these patients had a named GP and a structured annual review to check their health and medicines needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

## Families, children and young people

The practice is rated as good for the care of families, children and young people.

- There were systems to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young patients who had a high number of accident and emergency (A&E) attendances. Immunisation rates were either in line with or slightly above CCG and national averages for all standard childhood immunisations.
- Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals.
- The practice provided support for premature babies and their families following discharge from hospital.
- The practice performance for screening women for cervical cancer was in line with local and national averages. For example, 84% of women aged 25-64 had a record of a cervical screening test in the last 5 years, compared with the CCG average of 83% and the national average of 82%.
- Appointments were available outside of school hours and the premises were suitable for children and babies.
- The practice held quarterly safeguarding children meetings with the health visitor team and had regular contact in between.
- The practice had emergency processes for acutely ill children and young patients and for acute pregnancy complications.
- The practice offers to carry out paediatric phlebotomy due to its rural location.

Good





# Summary of findings

## **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 been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care.
- The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group.

Good



## **People whose circumstances may make them vulnerable**

The practice is rated as good for the care of people whose circumstances may make them vulnerable.

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- End of life care was delivered in a coordinated way which took into account the needs of those whose circumstances may make them vulnerable.
- The practice offered longer appointments for patients with a learning disability.
- The practice regularly worked with other health care professionals in the case management of vulnerable patients. We saw evidence of meetings to make best interest decisions where required.
- The practice informed 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.

Good



## **People experiencing poor mental health (including people with dementia)**

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia).

- 87% of patients diagnosed with dementia had had their care reviewed in a face to face meeting in the last 12 months, which is in line with the clinical commissioning group (CCG) average of 86% and the national average of 84%.

Good



# Summary of findings

- The practice specifically considered the physical health needs of patients with poor mental health.
- The practice had a system for monitoring repeat prescribing for patients receiving medication for mental health needs.
- Performance for support to patients with schizophrenia, bipolar affective disorder and other psychoses was better than local and national averages. For example, 95% of patients with a diagnosed psychological condition had a comprehensive, agreed care plan documented in their records, in the last 12 months, compared with the CCG average of 92% and the national average of 88%.
- The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia.
- Patients at risk of dementia were identified and offered an assessment.
- The practice carried out advance care planning for patients with dementia.
- The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations.
- The practice had a system in place to follow up patients who had attended accident and emergency where they may have been experiencing poor mental health.
- Staff had a good understanding of how to support patients with mental health needs and dementia.

# Summary of findings

## What people who use the service say

The national GP patient survey results were published in July 2016. The results showed the practice was performing above local and national averages. There were 217 survey forms distributed and 118 were returned. This represented approximately 2% of the practice's patient list.

- 92% of patients found it easy to get through to this practice by phone compared with the national average of 73%.
- 84% of patients were able to get an appointment to see or speak to someone the last time they tried compared with the national average of 76%.
- 90% of patients described the overall experience of this GP practice as good compared with the national average of 85%.
- 91% of patients said they would recommend this GP practice to someone who has just moved to the local area compared with the national average of 80%.

As part of our inspection we also asked for CQC comment cards to be completed by patients prior to our inspection. We received thirty one comment cards which were all positive about the standard of care received. Patients told us they were respected and treated well by all staff at the practice and they could see the GP of their choice. One patient said they received a phone call from their GP to check on their welfare when they were receiving treatment for a long term illness.

We spoke with six patients during the inspection, three of which were from the Patient Participation Group. All six patients said they were satisfied with the care they received and thought staff were approachable, committed and caring.

# Somerton House Surgery

## 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 adviser and a practice manager advisor.

## Background to Somerton House Surgery

Somerton House Surgery is located in the village of Midsomer Norton near Radstock. The practice serves a local and rural population of approximately 6600 patients from the village and the surrounding area.

There is parking on site including spaces for patients with a disability. The practice has a number of rooms which it makes available to other services; these include physiotherapy, counselling, drug misuse services and private sport physio.

The practice has five GPs; four partners and a salaried GP of which; four are female and one is male. Between them they provide 28 GP sessions each week and are equivalent to 3.5 whole time employees. There is a nurse practitioner who is qualified to prescribe particular medicines and a practice nurse, they provided 15 sessions per week and are the equivalent to 1.6 whole time employees. There was one health care assistant and two phlebotomists, they provided 10 sessions per week and their working hours are the equivalent to 2.4 whole time employees (WTE). The GPs and nurses are supported by a practice manager and eight administrative staff.

The practice is a GP training practice and had one registrar GP placed with them at the time of our inspection. The

practice also hosts placements for fifth year medical students. One of the GP partners is a GP trainer and the practice had been graded as excellent by the Severn Deanery GP Specialty Training Quality Panel.

The general Index of Multiple Deprivation (IMD) population profile for the geographic area of the practice is in the ninth least deprivation decile. (An area itself is not deprived: it is the circumstances and lifestyles of the people living there that affect its deprivation score. It is important to remember that not everyone living in a deprived area is deprived and that not all deprived people live in deprived areas). Average life expectancy for males in the area is 80 years, which is one year longer than the national average and for females is 85 years, which was slightly longer than the national average.

The practice is open between 8:15am and 6:15pm Monday to Friday. Telephone access is available from 8am until 6pm. The practice operates a mixed appointments system with some appointments available to pre-book and others available to book on the day.

GP appointments are 10 minutes each in length and appointment sessions are typically 8:20am until 11:30am and 3pm until 6pm. Each consultation session has 18 appointment slots. The practice offers online booking facilities for non-urgent appointments and an online repeat prescription service. Patients need to contact the practice first to arrange for access to these services. Extended hours appointments are offered two evenings from 6:30pm until 7pm and one early morning from 7:30am until 8am. Also early morning appointments with the phlebotomist are available two mornings a week on a Tuesday and Friday from 7:30am until 8am. Pre-bookable appointments are also available from 8:30am until 11:30am once a month on a Saturday.

# Detailed findings

The practice has opted out of providing out-of-hours services to their own patients. Patients are directed to using the NHS 111 telephone service outside of normal practice hours, who work in conjunction with Vocare out of hours GP service.

The practice has a Personal Medical Services contract to deliver health care services; the contract includes enhanced services such as childhood vaccination and immunisation scheme, facilitating timely diagnosis and support for patients with dementia, minor surgery services and avoiding unplanned admissions. These contracts act as the basis for arrangements between the NHS Commissioning Board and providers of general medical services in England.

This report relates to the registered regulated activities which were provided at the following location:

Somerton House Surgery

79a North Road

Midsomer Norton

Bath

BA3 2QE

## Why we carried out this inspection

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

## How we carried out this inspection

Before visiting, we reviewed a range of information we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 20 October 2016.

During our visit we:

- Spoke with a range of staff (including GPs, nurses and management and administration staff) and spoke with patients who used the service.
- Observed how patients were being cared for and talked with carers and/or family members
- Reviewed a sample of the personal care or treatment records of patients.
- Reviewed comment cards where patients and members of the public shared their views and experiences of the service.

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

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

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

# Are services safe?

## Our findings

### Safe track record and learning

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

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

We reviewed safety records, incident reports, patient safety alerts and minutes of meetings where these were discussed. We saw evidence that lessons were shared and action was taken to improve safety in the practice. For example, a patient required assistance in a medical emergency and staff had acted quickly to provide the patient with lifesaving medicine. However, after the incident it was established that an out of date medicine had been given to the patient. The practice recorded this as a significant event and acted on the agreed learning to prevent out of date medicines being given again.

### Overview of safety systems and processes

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

- Arrangements were in place to safeguard children and vulnerable adults from abuse. These arrangements reflected relevant legislation and local requirements. Policies were accessible to all staff. The policy for safeguarding adults clearly outlined who to contact for further guidance if staff had concerns about a patient's welfare. There was a lead member of staff for safeguarding. The GPs attended safeguarding meetings

when possible and always provided reports where necessary for other agencies. Staff demonstrated they understood their responsibilities and all had received training on safeguarding children and vulnerable adults relevant to their role. GPs and practice nurses were trained to child safeguarding level 3. Health care assistants and administration staff were trained to child safeguarding level 1 or 2.

- A chaperone poster was displayed in the waiting room which advised patients that chaperones were available if required. All staff who acted as chaperones were trained for the role and had received a Disclosure and Barring Service (DBS) check. (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).
- The practice maintained appropriate standards of cleanliness and hygiene. We observed the premises to be clean and tidy. The practice nurse was the infection control clinical lead who liaised with the local infection prevention teams to keep up to date with best practice. There was an infection control policy in place (last reviewed in March 2015 and due for review in March 2017). The majority of staff had received up to date training in infection control, however, two members of staff had no record of up to date training. The practice provided evidence, within 48 hours of the inspection, that both identified members of staff had completed infection control update training. Annual infection control audits were undertaken and we saw evidence that action was taken to address any improvements identified as a result.
- The arrangements for managing medicines, including emergency medicines and vaccines, in the practice kept patients safe (including obtaining, prescribing, recording, handling, storing, security and disposal). Processes were in place for handling repeat prescriptions which included the review of high risk medicines. The practice carried out regular medicines audits, with the support of the local clinical commissioning group (CCG) pharmacy teams, to ensure prescribing was in line with best practice guidelines for safe prescribing. Blank prescription forms and pads were securely stored and there were systems in place to monitor their use.
- One of the nurses had qualified as an Independent Prescriber and could therefore prescribe medicines for

## Are services safe?

specific clinical conditions. They received mentorship and support from the medical staff for this extended role and we saw plans to improve the recording of this in supervision logs.

- Patient Group Directions had been adopted by the practice to allow nurses to administer medicines in line with legislation. Health Care Assistants were trained to administer vaccines and medicines against a patient specific prescription or direction from a prescriber.
- The practice held stocks of controlled drugs (medicines that require extra checks and special storage because of their potential misuse) and had procedures in place to manage them safely. There were also arrangements in place for the destruction of controlled drugs.
- We reviewed three personnel files and found appropriate recruitment checks had been carried out, including proof of identification, qualifications and registration with the appropriate professional body. However, we found that the process for recruitment checks had not been fully implemented prior to employment. For example, all staff had a record of a Disclosure and Barring Service (DBS) check, however, we found some had been received post-employment. Two clinical staff had a record of a DBS check dated after they started employment. There were no written references in the files we reviewed. The practice manager told us verbal references were taken prior to employment and all three had provided up to three years satisfactory employment for the practice. The practice confirmed, within 48 hours of the inspection, that all personnel files had been reviewed and where no written references were in place, annual appraisal records had been reviewed and a note placed on file confirming satisfactory service in lieu of references.

### Monitoring risks to patients

Risks to patients were assessed and well managed.

- There were procedures in place for monitoring and managing risks to patient and staff safety. The practice

had up to date fire risk assessments and carried out regular fire drills and fire alarm checks. All electrical equipment was checked to ensure the equipment was safe to use and clinical equipment was checked to ensure it was working properly. The practice had a variety of other risk assessments in place to monitor safety of the premises such as control of substances hazardous to health and infection control and legionella (Legionella is a term for a particular bacterium which can contaminate water systems in buildings).

- Arrangements were in place for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. There was a rota system in place for all the different staffing groups to ensure enough staff were on duty. The practice had last audited its skill mix in January 2016.

### Arrangements to deal with emergencies and major incidents

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

- All staff received annual basic life support training and there were emergency medicines available in the treatment room.
- The practice had a defibrillator available on the premises and had adult pads available. The practice had reviewed the need for defibrillator pads for children and provided a copy of a risk assessment confirming that all medical emergencies could be addressed in the absence of defibrillator pads for children. Oxygen, with adult and children's masks, was available.
- Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. All the medicines we checked were in date and stored securely.
- The practice had a comprehensive business continuity plan in place for major incidents such as power failure or building damage. The plan included emergency contact numbers for staff.



# Are services effective?

(for example, treatment is effective)

## Our findings

### Effective needs assessment

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

- The practice had systems in place to keep all clinical staff up to date. Staff had access to guidelines from NICE and used this information to deliver care and treatment that met patients' needs.
- The practice monitored that these guidelines were followed through risk assessments, audits and random sample checks of patient records.

### Management, monitoring and improving outcomes for people

The practice used the information collected for the Quality and Outcomes Framework (QOF) and performance against national screening programmes to monitor outcomes for patients. (QOF is a system intended to improve the quality of general practice and reward good practice). The most recent published results were 98.3% of the total number of points available compared with the clinical commissioning group (CCG) average of 97.5% and national average of 94.8%.

Exception reporting in clinical domains was 7% overall which was lower than the clinical commissioning group (CCG) average of 10% and the national average of 9%. (Exception reporting is the removal of patients from QOF calculations where, for example, the patients are unable to attend a review meeting or certain medicines cannot be prescribed because of side effects).

This practice was not an outlier for any QOF (or other national) clinical targets. Data from 2014/15 showed:

- Performance for diabetes related indicators was similar to the CCG and national averages. For example, 93% of patients on the diabetes register had a record of a foot examination and risk classification within the last year, compared with the CCG average of 92% and the national average of 88%.
- Performance for mental health related indicators was similar to the CCG and national average. For example,

87% of patients diagnosed with dementia had their care reviewed in a face-to-face review in the preceding last year, compared with the CCG average of 86% and the national average of 84%.

There was evidence of quality improvement including clinical audit:

- There had been 13 clinical audits completed in the last two years, we saw one of these where we had seen improvements made which were implemented and monitored.
- Findings were used by the practice to improve services. For example, we saw an audit had been carried out of patients who had chronic kidney disease and cardiovascular disease and who would benefit from taking a specific medicine, in line with National Institute for Health and Care Excellence guidance. We saw an improvement from the initial audit in 2015 when 72% of patients were taking the medicines compared to the re-audit in January 2016 when 91% were taking the medicines.

### Effective staffing

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

- The practice had an induction programme for all newly appointed staff. This covered such topics as safeguarding, infection prevention and control, fire safety and health and safety.
- The practice could demonstrate how they ensured role-specific training and updating for relevant staff. For example, for those reviewing patients with long-term conditions and treating leg ulcers.
- Staff administering vaccines and taking samples for the cervical screening programme had received specific training which had included an assessment of competence. Staff who administered vaccines could demonstrate how they stayed up to date with changes to the immunisation programmes, for example by access to on line resources and discussion at practice meetings.
- The learning needs of staff were identified through a system of appraisals, meetings and reviews of practice development needs. Staff had access to appropriate training to meet their learning needs and to cover the scope of their work. This included ongoing support,



# Are services effective?

## (for example, treatment is effective)

one-to-one meetings, coaching and mentoring, clinical supervision and facilitation and support for revalidating GPs. All staff had received an appraisal within the last 12 months.

- Staff received training that included: safeguarding, fire safety awareness, basic life support and information governance. Staff had access to and made use of e-learning training modules and in-house training. During the inspection we found some gaps in the training records, showing that not all staff had up to date training in all relevant topics. For example, two members of staff did not have a record of up to date training in safeguarding children. We spoke to the practice who provided, within 48 hours of the inspection, confirmation that both had completed update training. We subsequently received evidence that the system for monitoring training was being fully implemented to ensure all staff were up to date. For example, staff were booked on a training covering safeguarding and other relevant topics in March 2017.
- The practice is a training practice and one GP trainee had just completed a placement with them at the time of our inspection. The practice also hosts placements for medical students. One of the GPs is a GP trainer and the practice had been graded as excellent by the Severn Deanery GP Specialty Training Quality Panel.

### Coordinating patient care and information sharing

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

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

Staff worked together and with other health and social care professionals to understand and meet the range and complexity of patients' needs and to assess and plan ongoing care and treatment. This included when patients moved between services, including when they were referred, or after they were discharged from hospital. Meetings took place with the community teams fortnightly, with palliative care nurses and health visitors quarterly, when care plans were routinely reviewed and updated for patients with complex needs.

The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

The practice had close links with the nursing and residential homes where some patients resided. They attended two nursing homes on weekly ward rounds in addition to any urgent visits and this was carried out by the lead GP. This enabled patients and staff to have a consistency of care and treatment. The practice worked with two other GP practices coordinating care within a large nursing home which had approximately one hundred residents. They met on a quarterly basis and discussed safeguarding, incidents, deaths and admissions to hospital. This was then shared with the local clinical commissioning group (CCG).

### Consent to care and treatment

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

- Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act 2005.
- When providing care and treatment for children and young people, staff carried out assessments of capacity to consent in line with relevant guidance.
- Where a patient's mental capacity to consent to care or treatment was unclear the GP or practice nurse assessed the patient's capacity and, recorded the outcome of the assessment. We saw evidence that the practice hosted best interest meetings within the practice to assist with decision making.

### Supporting patients to live healthier lives

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

- Patients receiving end of life care, carers, those at risk of developing a long-term condition and those requiring advice on their diet, smoking and alcohol cessation were signposted to the relevant service.
- A psychological practitioner, talking therapies counsellor and a drug counsellor was available on the premises.

# Are services effective?

(for example, treatment is effective)

- The practice's uptake for the cervical screening programme was 84% which was comparable with the clinical commissioning group (CCG) average of 83% and the national average of 82%.
- The uptake for bowel cancer screening for 60-69 years olds was 63% which was comparable with the CCG average of 61% and national average of 58%.
- The uptake for breast cancer screening for 50-70 year olds was 79% which was above the CCG average of 73% and national average of 72%.
- Childhood immunisation rates for the vaccinations given were slightly below CCG and national averages for

under two year olds; and slightly above CCG and national averages for two to five year olds. For example, childhood immunisation rates for the vaccinations given to under two year olds ranged from 91% to 95% and five year olds from 93% to 100%.

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

# Are services caring?

## Our findings

### Kindness, dignity, respect and compassion

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

- Curtains were provided in consulting rooms to maintain patients' privacy and dignity during examinations, investigations and treatments.
- Consultation and treatment room doors were closed during consultations; conversations taking place in these rooms could not be overheard.
- Reception staff knew that if patients wanted to discuss sensitive issues or appeared distressed they could offer them a private room to discuss their needs.
- Same sex clinicians were offered where appropriate.

All of the thirty one patient Care Quality Commission comment cards we received were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were helpful, caring and treated them with dignity and respect.

We spoke with six patients including three members of the patient participation group (PPG). They told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected. Comments highlighted that staff responded compassionately when they needed help and provided support when required.

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

- 96% of patients said the GP was good at listening to them compared with the clinical commissioning group (CCG) average of 93% and the national average of 89%.
- 94% of patients said the GP gave them enough time compared with the CCG average of 91% and the national average of 87%.
- 98% of patients said they had confidence and trust in the last GP they saw compared with the CCG average of 98% and the national average of 95%.

- 91% of patients said the last GP they spoke to was good at treating them with care and concern compared with the CCG average of 91% and the national average of 85%.
- 93% of patients said the last nurse they spoke to was good at treating them with care and concern compared with the CCG average of 94% and the national average of 91%.
- 94% of patients said they found the receptionists at the practice helpful compared with the CCG average of 94% and the national average of 87%.

The views of external stakeholders were positive and in line with our findings. For example, the managers of the three local care homes where some of the practice's patients lived all praised the care provided by the practice. Each care home had a nominated GP who visited patients each week. We saw evidence of a thorough and effective liaison meeting between the manager of one large care home, where patients registered at three local GP practices lived, and the nominated GPs from this and two other practices.

### Care planning and involvement in decisions about care and treatment

Patients told us they felt involved in decision making about the care and treatment they received. They 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 available to them. Patient feedback from the comment cards we received was also positive and aligned with these views. We also saw that care plans were personalised.

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

- 91% of patients said the last GP they saw was good at explaining tests and treatments compared with the clinical commissioning group (CCG) average of 91% and the national average of 86%.
- 94% of patients said the last GP they saw was good at involving them in decisions about their care compared with the CCG average of 88% and the national average of 82%.

## Are services caring?

- 93% of patients said the last nurse they saw was good at involving them in decisions about their care compared with the CCG average of 89% and the national average of 85%.

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

- 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 patients this service was available.
- There was a signing service and hearing loop available for patients who had a hearing impairment.

### **Patient and carer support to cope emotionally with care and treatment**

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

Information about support groups was also available on the practice website. Support for isolated or house-bound patients included signposting to relevant support and volunteer services.

The practice's computer system alerted GPs if a patient was also a carer. The practice had identified 122 patients as carers (2% of the practice list). Carers were offered annual health checks with the GP and prioritised for appointments. Written information was available to direct carers to the various avenues of support available to them.

A member of staff acted as a carers' champion to help ensure that the various services supporting carers were coordinated and effective.

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

# Are services responsive to people's needs?

(for example, to feedback?)

## Our findings

### Responding to and meeting people's needs

The practice understood its population profile and had used this understanding to meet the needs of its population:

- The practice offered an extended hours for patients who could not attend during normal opening hours which were offered two evenings a week from 6:30pm until 7pm and one early morning from 7:30am until 8am. Also early morning appointments with the phlebotomist were available two mornings a week on a Tuesday and Friday from 7:30am until 8am. Pre-bookable appointments were also available from 8:30am until 11:30am once a month on a Saturday.
- There were longer appointments available for patients with a learning disability.
- Home visits were available for older patients and patients who had clinical needs which resulted in difficulty attending the practice.
- The practice took account of the needs and preferences of patients with life-limiting progressive conditions. There were early and ongoing conversations with these patients about their end of life care as part of their wider treatment and care planning.
- Same day appointments were available for children and those patients with medical problems that require same day consultation.
- Patients were able to receive travel vaccinations available on the NHS as well as those only available privately.
- There were disabled facilities, a hearing loop and translation services available including sign language.
- The practice had two GPs who led in the monitoring of patients who resided in a residential or nursing homes. They had regular liaison with the homes, for example, by attending the nursing homes weekly on ward rounds in addition to urgent home visits. They also attended a quarterly meeting with two other practices for one of the nursing homes to enhance the coordination of care.

### Access to the service

The practice was open between 8:15am and 6:15pm Monday to Friday. GP appointments were 10 minutes each in length unless a longer appointment had been requested. Appointments were available from 8:20am until 11:30am

every morning and 3pm until 6pm daily. Extended hours appointments were offered from 7:30am until 8am and from 6:30pm until 7pm on Mondays. Pre-bookable appointments were also available from 8:30am until 11:30am on Saturdays once a month. In addition to pre-bookable appointments that could be booked up to six weeks in advance, urgent appointments and telephone consultations were also available for patients that needed them. The practice offers online booking facilities for non-urgent appointments and an online repeat prescription service. Patients need to contact the practice first to arrange for access to these services.

Results from the national GP patient survey showed that patient's satisfaction with how they could access care and treatment was comparable to local and national averages.

- 80% patients were satisfied with the practice's opening hours compared with the clinical commissioning group (CCG) average of 81% and the national average of 76%.
- 92% of patients said they could get through easily to the practice by phone compared with the CCG average of 91% and the national average of 73%.

Patients told us on the day of the inspection that they were able to get appointments when they needed them.

The practice had a system in place to assess:

- whether a home visit was clinically necessary; and
- the urgency of the need for medical attention.

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

### Listening and learning from concerns and complaints

The practice had an effective 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 who handled all complaints in the practice.

# Are services responsive to people's needs?

(for example, to feedback?)

- We saw that information was available to help patients understand the complaints system. There was a poster displayed in the reception area to ask patients to contact the practice manager or speak with reception. Reception were then able to give information to patients about the complaints process and how to complain. However, patients had to ask for details and there was no clear information on the website to enable patients to make a complaint.
- The practice had good practice in sending patients a satisfaction questionnaire three months following they had received their response to the complaint to check if the practice could further improve their service.

We looked at eleven complaints received in the last 12 months and found these were satisfactorily handled, dealt with in a timely way, openness and transparency with dealing with the complaint. Lessons were learned from individual concerns and complaints and also from analysis of trends and action was taken to as a result to improve the quality of care.

# Are services well-led?

Good 

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

## Our findings

### Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice had a mission statement which was displayed in the waiting areas and on the practice website. Staff knew and understood the values which were:

- Striving to provide exemplary care for each of our patients and their families in a safe infection free environment complying with the Health and Social Care Act 2008.
- Building a work environment where each person was valued and respected
- Maintaining strong relationships with other agencies and our community
- Demonstrating responsibility through our fair use of resources

The practice had a strategy and supporting business development plan which reflected the vision and values and were regularly monitored. The plan was published in October 2015 and we saw evidence of actions, allocated to named staff, covering, for example, staff training, premises development, financial planning and workforce planning. We were told the plan would be reviewed and updated in October 2016. We saw that all staff took an active role in ensuring high quality care on a daily basis and behaved in a kind, considerate and professional way.

### Governance arrangements

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

- There was a clear staffing structure and that staff were aware of their own roles and responsibilities. GPs and nurses had lead roles in key areas such as safeguarding, infection control, diabetes, medicines management and drug abuse.
- Practice specific policies were implemented and were available to all staff. These were updated and reviewed regularly.

- A comprehensive understanding of the performance of the practice was maintained. Whole practice meetings were held monthly which provided an opportunity for staff to learn about the performance of the practice. There was also a weekly business meeting.
- A programme of continuous clinical and internal audit was used to monitor quality and to make improvements. We saw to identify, assess, manage and monitor a range of risks.
- There were arrangements for identifying, recording, assessing managing and monitoring risks and implementing mitigating actions. For example, we saw a quality assurance system in place for risk management; and regular audits to monitor infection control and fire safety were carried out. However, there were some areas where improvement was required, such as the need to fully implement arrangements for recording of staff training and recruitment checks.
- There was a meetings structure that allowed for lessons to be learned and shared following significant events and complaints.

### Leadership and culture

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

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

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

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



# Are services well-led?

Good 

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

- The practice held and minuted a range of multi-disciplinary meetings including meetings with community nurses and palliative care nurses to monitor vulnerable patients. GPs, where required, met with health visitors to monitor vulnerable families and safeguarding concerns.
- Staff told us the practice held regular monthly team meetings.
- Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and felt confident and supported in doing so. Minutes were comprehensive and were available for practice staff to view.
- Staff said they felt respected, valued and supported, particularly by the partners in the practice. All staff were involved in discussions about how to run and develop the practice, and the partners encouraged all members of staff to identify opportunities to improve the service delivered by the practice.

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

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

- The practice had gathered feedback from patients through the patient participation group (PPG) and through surveys and complaints received. The PPG met monthly, carried out patient surveys and submitted proposals for improvements to the practice

management team. For example, the PPG had raised money from patients to purchase an additional six blood pressure monitors for patients loan use at home and a Doppler machine to improve patient care. The Doppler machine (used to check blood circulation) was a faster, more accurate and more effective way of providing treatment. For example we saw that appointment times for each patient were reduced from 40 minutes to 20 minutes and more accurate results resulted in appropriate referrals to hospital based specialists.

- The practice had gathered feedback from staff through generally through staff meetings, appraisals and informal discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged to improve how the practice was run.

## Continuous improvement

There was a focus on continuous learning and improvement at all levels within the practice. The practice team was forward thinking and part of local pilot schemes to improve outcomes for patients in the area. For example, we saw evidence of planning to work jointly on practice management with another two practices. This would enable them to share learning, make improvements to their own service and become more effective in the service provided. The practice was also working with a local college to assist with an apprentice scheme and provide work experience placements.



This section is primarily information for the provider

## Requirement notices

### Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 19 HSCA (RA) Regulations 2014 Fit and proper persons employed  <b>The provider did not do all that was reasonably practicable to establish and operate effective recruitment procedures to ensure that only staff who met the requirements of the regulations were employed.</b>  This was in breach of regulation 19(2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.