Dunster Surgery

Quality Report

3 Park Street, Dunster
Somerset, TA24 6SR
Tel: 01643 821244
Website: www.dunsterandporlocksurgeries.co.uk

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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	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Outstanding ☆
Are services caring?	Outstanding ☆
Are services responsive to people's needs?	Outstanding ☆
Are services well-led?	Outstanding ☆

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

OUTSTANDING

We carried out an announced comprehensive inspection at Dunster Surgery on 18 May 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing responsive, caring, effective and well led services. It was also outstanding for providing services for older people and people with long term conditions. It was good for providing safe services. It was also good for providing services to the working aged population including those recently retired and students, families, children and young people, people with poor mental health and people whose circumstances make them vulnerable.

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

- 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.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment. Information was provided to help patients understand the care available to them.
- The practice worked closely with other organisations and with the local community in planning how services were provided to ensure they met people's needs.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the patient participation group (PPG).
- The practice had good facilities and was well equipped to treat patients and meet their needs. Information about how to complain was available and easy to understand.

Summary of findings

- The practice had a clear vision which had quality and safety as its top priority. A business plan was in place, was monitored and regularly reviewed and discussed with all staff. High standards were promoted and owned by all practice staff with evidence of team working across all roles.

We saw several areas of outstanding practice including:

We saw that the practice was responsive to the needs of the local population. For example, the practice had increased the flexibility of access to appointments and could demonstrate the impact of this by reduced use of the Out Of Hours and secondary acute service and very positive patient survey results. The practice had a very good skill mix which included a home support nurse to visit the isolated; those with a high risk of hospital admission and those with a high need for medical care. The practice provided comprehensive screening and regular reviews for patients at risk of developing long term conditions. As well as additional planned medicine and health reviews of patients with long term conditions. The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice; which comprised of a project with Age UK to provide support for isolated patients and tele-consultations and practice visits with patients by specialist hospital consultants. The practice had involved the patient participation group (PPG) in the recruitment of a new GP giving patients the majority on the choice of candidate.

We saw that the practice cared for the population through provision of additional services to enable end of life patients to remain at home. This included funding a night sitter nursing service for the local population; direct contact with a practice GP out of hours and providing additional clinical interventions normally undertaken in a hospital. The practice had reached out to the local community in order to prevent illness by providing an annual flu vaccination clinic which included invitation to local organisations to attend; an annual men's health evening to promote better health and working with local and national media to promote reading well for self-help. All these were not limited to the practice population. The practice had undertaken a project with Age UK to provide support to isolated patients.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good 

The practice is rated as good for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Lessons were learned and communicated widely to support improvement. Information about safety was recorded, monitored, appropriately reviewed and addressed. Risks to patients were assessed and well managed. There were enough staff to keep patients safe.

Are services effective?

Outstanding 

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that systems were in place to ensure all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm these guidelines were positively influencing and improving practice and outcomes for patients. Data showed the practice was performing highly when compared to neighbouring practices in the Clinical Commissioning Group. The practice used innovative and proactive methods to improve patient outcomes and it linked with other local providers to share best practice.

Are services caring?

Outstanding 

The practice is rated as outstanding for providing caring services. Data showed that patients rated the practice higher than others for almost all aspects of care. Feedback from patients about their care and treatment was consistently and strongly positive. We observed a patient-centred culture. Patients emotional and social needs were seen as important as their physical needs. Staff were motivated and inspired to offer kind and compassionate care and worked to overcome obstacles in achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted upon. Views of external stakeholders were very positive and aligned with our findings.

Are services responsive to people's needs?

Outstanding 

The practice is rated as outstanding for providing responsive services. The practice had initiated positive service improvements for its patients that were over and above its contractual obligations. It acted upon suggestions for improvements and changed the way it delivered services in response to feedback from the Patient

Summary of findings

Participation Group (PPG). The practice reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure service improvements where these had been identified.

Patients told us it was easy to get an appointment with a named GP or a GP of choice, there was continuity of care and urgent appointments available on 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 and easy to understand, and the practice responded quickly when issues were raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Outstanding ☆

The practice is rated as outstanding for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. High standards were promoted and owned by all practice staff and teams worked together across all roles. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted upon. The patient participation group (PPG) was very active and involved with business decisions. Staff had received inductions, regular performance reviews and attended staff meetings and events. The practice carried out proactive succession planning.

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

Outstanding ☆

The practice is rated as outstanding for the care of older people. Over 75s account for 15% of the practice population. This is higher than the Somerset average of 10% and puts the practice in the top 10% of practices for older populations. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, in caring for people living with dementia and for those who require end of life care. It was responsive to the needs of older people, and offered home visits and rapid access appointments for those with enhanced needs.

Patients with a high need for medical care; at risk of hospital admission or isolated were referred to the practice home support nurse to provide additional support in their own home. This included referral to multidisciplinary teams and voluntary sector services. In addition the practice had recently started a project with Age UK to improve lives of isolated older patients and encourage them to maintain active healthy living.

Patients received enhanced end of life care with a night sitter nursing service funded by the practice.

The practice provided an annual flu event where anyone from the local population could attend for a flu vaccination and advice or support from a number of agencies.

People with long term conditions

Outstanding ☆

The practice is rated as outstanding for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management and offered longer appointments, six monthly which included anxiety and depression screening and personal management plans. This was in addition to a structured annual review with a named GP. Housebound patients received an annual home visit from the nurses to carry out a health review.

For those people with the most complex needs, the practice worked closely with relevant health and care professionals to deliver a multidisciplinary package of care. For example the endocrinologist; cardiologist and diabetic specialist nurse attended the practice to carry out joint reviews and education sessions. In addition the nurse run pulmonary rehabilitation clinics.

Summary of findings

A significant event had led the practice to lobby for national coding for poor inhaler compliance.

Patients with a high need for medical care; at risk of hospital admission or isolated were referred to the practice home support nurse to provide additional support in their own home. This included referral to multidisciplinary teams and voluntary sector services.

Patients received enhanced end of life care with a night sitter nursing service funded by the practice.

The practice has a high rate of health screening and health promotion. For example, patients with high blood pressure undergo comprehensive yearly checks for diabetes and ECG screening is regularly used in this group of people to diagnose any evolving heart conditions. The practice provided an annual flu event where anyone within the target group from the local population could attend for a flu vaccination and advice or support from a number of agencies.

The GPs had undertaken additional clinical skills, for example minor surgery, so patients did not have a long journey to hospital.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were very high for all standard childhood immunisations. Patients told us children and young people were treated in an age-appropriate way and were recognised as individuals, and we saw evidence to confirm this. Appointments were available outside of school hours and the premises were suitable for children and babies. We saw good examples of joint working with midwives, health visitors and school nurses. As part of a local agreement any young person in the local area could attend the practice and be seen by a GP.

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age people (including those recently retired and students). The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services 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 reflected the needs of this age group.

Summary of findings

The practice went beyond the expectations of their contract with regards to early screening for diseases. For example diagnostic blood tests for diabetes were used for patients at risk. In conjunction with the local GP federation and patient participation group, the practice ran an annual men's health event.

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. The practice held a register of patients living in vulnerable circumstances including those with a learning disability; patients with significant mental ill-health and housebound patients. It offered longer appointments for people with a learning disability and had carried out annual health checks for patients with a learning disability with eight out of nine of these patients receiving a follow up.

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

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia). All patients experiencing poor mental health had received an annual physical health check which included preventative health screening for heart disease. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those living with dementia. It carried out advance care planning for patients living with dementia.

The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations. It had a system in place to follow up patients who had attended accident and emergency (A&E) where they may have been experiencing poor mental health. The practice had a close working relationship with the community mental health team. Patients with early signs of memory loss were referred to support services.

GPs had undertaken additional training in caring for patients living with dementia and had worked with the local Psychogeritrician to provide clinics at the practice. We saw the practice was proactive in

Summary of findings

supporting patients with poor mental health. The practice was the highest user of self-help books in Somerset and one GP had engaged with local and national media to promote the benefits of this therapy.

Summary of findings

What people who use the service say

We spoke with six patients who visited the practice and members of the patient participation group (PPG) during our inspection. We reviewed 29 patient comment cards from our Care Quality Commission (CQC) comments box that had been placed in the practice prior to our inspection. We saw the comments were all positive and described the service as excellent. Patients told us the practice was clean and hygienic; staff were motivated, caring, empathetic and patient focused whilst treating patients with dignity and respect; staff were helpful and motivated whilst providing an excellent service.

The practice had an active patient participation group (PPG) with nine members of varied ages and representation from the population groups. The chair person was active in the local older person health forum and the group actively engage with Healthwatch. The PPG members we spoke with told us the GPs actively engaged and supported the group and the staff were aware of the different needs of the practice population. The GP partners attended all PPG meetings and the PPG told us they were receptive, interested in improving patient experience and proactive in implementing new ideas for service delivery. The PPG were also encouraged to attend practice meetings and were involved with the recruitment of a new GP. We saw the most recent PPG survey (October 2014). We could see evidence during our inspection; the practice had addressed a concern raised by the PPG from a patient with regards to cleanliness. The PPG told us the quality of medical service was outstanding and patients were happy with the efficient service provided.

We looked at data provided in the most recent NHS GP patient survey (January 2015) and the Care Quality Commission's information management report about the practice. We saw 93% of patients described their overall experience of this practice as good.

We also looked at the data provided by NHS England for the Friends and Family Test (FFT) in February, March and April 2015. The FFT is a feedback tool which offered patients of NHS-funded services the opportunity to provide feedback about the care and treatment they have received. For these three months 98-100% of patients would recommend the service they had received to their friends and family.

Outstanding practice

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and national media to promote reading well for self-help. All these were not limited to the practice population. The practice had undertaken a project with Age UK to provide support to isolated patients.

Dunster Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team included a GP, Expert by Experience, CQC Pharmacist and a CQC inspector.

Background to Dunster Surgery

Dunster surgery provides primary medical services to approximately 2000 patients living in Dunster and the surrounding area of Exmoor national park in Somerset. The practice provides primary care to seven residential homes and two nursing homes.

The South West UK Census data (2011) shows 98% of the population are recorded as white British. Public Health Somerset's general practice profile shows that 11.8% of the registered population are aged 0-14 years old, which is much lower than the rest of Somerset at 16.1%. And 15% of the registered population are aged 75 years and over which is much higher than the Somerset average of 10.4%. A higher than England average group of patients aged over 55 is reflected by West Somerset having the longest living population in Europe with over 40% of pensionable age (Office National statistics 2010). The practice population have higher levels of deprivation (22.6%) than the average for Somerset (16.9%).

The surgery is currently in two terraced houses which were converted some time ago. The building is set over two floors with patient services provided on the ground floor. The practice includes a dispensary which 75% of patients use. A purpose built medical centre is currently under construction.

The practice team includes two GP partners (male) and a salaried GP (female); two practice nurses; one healthcare assistant; a home support nurse; a practice manager; dispensary and administration staff. All three GP's, some of the nursing team and the practice manager work across this practice and Porlock Medical Centre. Dr Kelham began management of Dunster Surgery in 2009 and the two practices share governance and staff and are registered as separate providers with the CQC. Dr Davies became a partner in 2009 and although both GP's work over both practices they are registered as separate businesses.

The practice also worked with community staff including health visitors, district nurses the community health team for older people and a midwife. The practice worked closely with a local carers support organisation that provide support services within the practice. Age UK were working with the practice to provide support to older people with long term conditions who are isolated.

The practice provides training for trainee doctors and GP Registrars.

The practice had a General Medical Services contract (GMS) with NHS England to deliver general medical services.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access NHS 111 out of hours and Somerset Doctors Urgent Care provided an Out Of Hours GP service. The practice did provide patients receiving end of life care with GP personal telephone numbers to ensure continuity of care during these times.

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

Detailed findings

part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

How we carried out this inspection

We carried out an announced visit to the practice on 18 May 2015 when we spoke with eleven staff and four patients, looked at documentation and observed how people were being cared for.

In advance of the inspection we reviewed the information we held about the provider and asked other organisations to share what they knew. We spoke with Somerset Clinical Commissioning Group, NHS England Area Team and Somerset Healthwatch. We reviewed comments cards, sent to the practice in advance of our visit for patients to complete. These were where patients and members of the public shared their views and experiences of the service. We also spoke to Health Visitors and the local community mental health team for older people who provided care for patients registered at the practice.

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 people and what good care looks like for them. The population groups are:

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

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety. For example, reported incidents and national patient safety alerts as well as comments and complaints received from patients. The staff we spoke with were aware of their responsibilities to raise concerns, and knew how to report incidents and near misses. For example the fridge in the Dispensary had a system to record temperature controls in the fridge. In November 2014 the dispensing manager reviewed the data and found there had been a fluctuation in temperature which could have caused the medicines to be unstable. We saw the dispensing manager followed correct procedures when they immediately reported the incident and contacted manufacturers of all the medicines to ensure the medicines were safe and would be effective when used. We saw the practice had a reporting process which included discussion at staff meetings; analysis of incidents; action plans and lessons learnt.

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

Learning and improvement from safety incidents

The practice had a system in place for reporting, recording and monitoring significant events, incidents and accidents. We reviewed records of five significant events that had occurred during the last year and saw this system was followed appropriately. Significant events were a standing item on the practice meeting agenda and if necessary a dedicated meeting was held to review actions from past significant events and complaints. There was evidence the practice had learnt from these and the findings were shared with relevant staff. Staff knew how to raise an issue for consideration at the meetings and they felt encouraged to do this should the need arise.

Staff used incident forms and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked all five incidents over the past year and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result of an investigation and how the learning had been shared. For example a patient had knocked over blood pressure monitoring equipment that contained mercury. This was identified at the practice, a serious incident process was followed and staff were included in the findings; lessons learnt and actions taken to mitigate future risk. We saw the practice was meeting Duty of Candour requirements. For example, where patients had been affected by something that had gone wrong they were given an apology and informed of the actions taken to prevent the same thing happening again.

National patient safety alerts were disseminated by the patient and medicine management pharmacist, dispensary lead or the practice manager to appropriate practice staff. Staff we spoke with were able to give examples of recent alerts that were relevant to the care for which they were responsible. For example, the prescribing of antiviral medicines during the winter and a potential risk from blood glucose monitoring strips. They also told us alerts were discussed at practice meetings (or sooner if alerts indicated immediate action was required) 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 all staff had received relevant role specific training about 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 were easily accessible.

The practice had appointed dedicated GPs as leads in safeguarding vulnerable adults and children. They had been trained to level three in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these lead professionals were and who to speak with in the practice if they had a safeguarding concern.

Good

Are services safe?

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 if they were a carer to a vulnerable patient. All children and young people who attended accident and emergency were monitored. We saw the nurses followed up any children who had failed to attend for childhood vaccinations.

We saw any missed appointments for vulnerable people were followed up by the GPs. The practice had a computer software programme which provided staff with alerts when patients did not attend routine blood tests appointments.

There was active engagement in local safeguarding procedures and effective working with other relevant organisations. We spoke to the Health Visitor who told us they met monthly with the GPs to discuss concerns. They had no concerns around staff engagement or knowledge of safeguarding children. The Health Visitor gave us examples of practice engagement with concerns for a mother with post-natal depression and a family with social problems. The practice provided evidence of good safeguarding multidisciplinary work. We were told about an example when an administrator recognised a historic safeguarding concern in the paper record of a new patient which had not been part of the electronic notes transferred by the previous practice. We saw the GP had discussions with the local authority to share information and when further concerns were raised effective communication occurred.

We saw evidence of good liaison with partner agencies. For example, we saw another example of a patient who had attended the practice with injuries and was known to be a survivor of abuse. The GPs told us about their engagement with multi agency safeguarding team, for example, case conferences. The practice had a policy to always provide a report for child case conferences. Case conferences were attended when held locally.

There was a chaperone policy, which was visible on the waiting room noticeboard and in consulting rooms. (A chaperone is a person who acts as a safeguard and witness for a patient and health care professional during a medical examination or procedure). All nursing staff, including health care assistants, had been trained to be a chaperone. All staff undertaking chaperone duties had received Disclosure and Barring Service (DBS) checks. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

Medicines management

We checked medicines stored in the Dispensary, treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensuring medicines were kept at the required temperatures and described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medicines were stored at the appropriate temperature.

The practice had appropriate written procedures in place for the production of prescriptions and dispensing of medicines that were regularly reviewed and accurately reflected current practice. The practice was signed up to the Dispensing Services Quality Scheme to help ensure processes were suitable and the quality of the service was maintained. Dispensing staff had all completed appropriate training and had their competency reviewed annually. We saw the practice undertook regular audits within the dispensary. For example a recent audit of instructions given to patients taking thyroid medicines led to additional instructions to optimise the effectiveness of the medicine. We saw the Dispensary had well-ordered storage of medicines for dispensing and completed prescriptions for collection.

Processes were in place to check medicines were within their expiry date and suitable for use. All the medicines we checked were within their expiry dates. Expired and unwanted medicines were disposed of in line with waste regulations.

All prescriptions were reviewed and signed by a GP before they were given to the patient. Both blank prescription forms for use in printers and those for hand written prescriptions were handled in accordance with national guidance as these were tracked through the practice and kept securely at all times.

The practice held stocks of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse) and had in place standard procedures that set out how they were managed. These were being followed by the practice staff. For

example, controlled drugs were stored in a controlled drugs cupboard and access to them was restricted and the keys held securely. There were arrangements in place for the destruction of controlled drugs.

We saw records of practice meetings which noted the actions taken in response to a review of prescribing data. One GP had responsibility of a prescribing lead which included determining which medicines would be described. Another GP was the dispensary lead. We saw that this system worked well and reduced conflicts of interest with regard to receiving any profit from the dispensing of medicines.

There was a system in place for the management of high risk medicines such as warfarin, methotrexate and other disease modifying drugs, which included regular monitoring in accordance with national guidance. The practice used software that alerted them to individual patients where there may be a medicines risk. These included patients who may have developed abnormalities in blood measurements which may relate to particular medicines being taken. An example was provided of how the system worked with a patient taking an anticoagulant medicine. Appropriate action was taken based on the results. We saw dispensary staff had a process to check that regular blood monitoring had been completed prior to issuing medicines to patients.

The practice had clear systems in place to monitor the prescribing of controlled drugs (medicines that require extra checks and special storage arrangements because of their potential for misuse). They carried out regular audits of the prescribing of medicines including controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs that had been updated in 2014. The health care assistant administered vaccines and other medicines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw evidence nurses and the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to either under a PGD or in accordance with a PSD from the prescriber. A member of the nursing staff was qualified as an independent prescriber and she received regular supervision and support in her role as well as updates in the specific clinical areas of expertise for which she prescribed.

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

Cleanliness and infection control

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

An up to date infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, personal protective equipment including disposable gloves, aprons and coverings were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control policy. The practice had a cleaning specification which included a monthly deep clean of the treatment and consulting rooms. There was also a policy for needle stick injury and staff knew the procedure to follow in the event of an injury.

The practice had a clinical and a non-clinical lead for infection control who had undertaken further training to enable them to provide advice about the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role. We saw evidence the lead had carried out audits for each of the last three years and that any improvements identified for action were completed on time. Minutes of meetings showed infection control was a regular agenda item.

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.

Good

Are services safe?

The practice had a policy for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings).We saw a risk assessment that confirmed the practice had not identified any potential risk due to there being no significant hazards. The practice did carry out a water flushing process in areas that were used infrequently.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date which was March 2015. A schedule of testing was in place. We saw evidence of calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

There were records for servicing to the boiler.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. Records we looked at contained evidence appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the correct professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable). We saw the health care assistant had a standard and not an enhanced DBS check, which is a check required for persons working with children or adults who could be at risk. We spoke to the practice and they provided proof after the inspection that an enhanced check had been received.

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. The practice manager showed us records to demonstrate that actual staffing levels and skill mix met planned staffing requirements.

We were told about the recruitment process of a new GP. The Patient Participation Group (PPG) had been actively involved in the selection process including interviews. When a decision was made as to which GP to recruit the PPG had the majority decisions.

All staff were provided with a staff handbook. Staff we spoke with were able to tell us about whistleblowing and knew where the policy was kept.

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. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

Identified risks were included on a risk log. Each risk was assessed and rated and mitigating actions recorded to reduce and manage the risk. Risks associated with service and staffing changes (both planned and unplanned) were required to be included on the log. We saw an example of this when a member of staff was pregnant. The meeting minutes we reviewed showed risks were discussed at GP partners' meetings and within team meetings.

We saw staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there were emergency processes in place for patients with long-term conditions. Staff gave us examples of referrals made for patients whose health deteriorated suddenly; how they responded to patients experiencing a mental health crisis, including supporting them to access emergency care and treatment. The practice monitored repeat prescribing for patients receiving medicines for mental health problems. For example patients receiving medicines that required monitoring through blood testing would have their medical records checked to ensure

attendance. We spoke to a patient on the day who told us they had missed their appointment that morning. The practice had rung them to arrange for them to come to the surgery later on so they did not miss their tests.

Arrangements to deal with emergencies and major incidents

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

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were 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.

We were told about two medical emergencies that happened at the practice. We saw all staff worked together effectively to stabilise the patient; carry out emergency care and provide effective handover to ambulance personnel.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document contained relevant contact details for staff to whom they could refer to.

We saw the contingency plan for the closure of the main road in Dunster, for 12 weeks in 2015. The closure cut off all patients south of the practice, many patients and staff had to take a 25 mile detour in order to get to the practice. We saw an effective plan had been put into place which included making use of a community building to provide patient services to those patients south of the practice and sourcing generators in case of power failure. We saw a lessons learnt analysis was completed afterwards which included actions to take in case of future disruption to services.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. Records showed staff were up to date with fire training and that they practised regular fire drills.

Outstanding ☆

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with could clearly outline the rationale for their approaches to treatment. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. We saw medical record templates included updated guidance from NICE.

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was downloaded from the website and disseminated to staff. They also told us the local patient and medicines management pharmacist provided regular summaries. We saw minutes of clinical meetings which showed this was then discussed and implications for the practice's performance and patients were identified and required actions agreed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective. For example, the practice had seven patients with long term mental illness and 100% had received a six monthly health check; 90% of diabetic patients had attended for an annual eye screening programme and 95% of the 581 patients with more than one condition had attended for a medicines review in the last year. Feedback from patients confirmed they were referred to other services or hospital when required.

The GPs told us they took lead roles in specialist clinical areas such as minor surgery, public health medicine, cardiology and ear, nose and throat medicine. The practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were open about asking for and providing colleagues with advice and support. GPs told us this supported all staff to review and discuss new best practice guidelines. For example, the use of talking therapies for patients with mental ill-health. Our review of the clinical meeting minutes confirmed this happened. We saw the practice was the highest user of self-help books for patients with psychological problems. One GP had been proactive in the re-launch of this service through local and national media interviews.

The practice used computerised tools to identify patients who were at high risk of admission to hospital. These patients were reviewed regularly to ensure multidisciplinary care plans were documented in their records and that their needs were being met to assist in reducing the need for them to go into hospital. We saw that 100% of the top 2% of patients with long term conditions who had been admitted to hospital had been followed up within three days of discharge to ensure that all their needs were continuing to be met.

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

Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. 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 14 clinical audits had been undertaken recently. Following each clinical audit, changes to treatment or care were made where needed and the audit was repeated when necessary to ensure outcomes for patients had improved. For example an audit was undertaken to review the effectiveness of shoulder injections. The results were then compared with the same audit at Porlock Medical Centre. Following the comparison audits the practice changed its policy so patients were advised of the expected outcomes to the procedure at the time consent to undertake the procedure was undertaken.

The practice showed us three clinical audits that had been undertaken in the last year. The GPs told us clinical audits were often linked to medicines management information,

safety alerts or as a result of information from the local quality and outcomes framework, Somerset Practice Quality Scheme (SPQS). (SPQS is a local incentive scheme for GP practices in Somerset). One of these was a completed audit for gout where the practice was able to demonstrate, following the audit results, a change to preventative treatment (in line with blood results rather than gout attacks) had been implemented to improve patient outcomes. A repeat audit showed an improvement when compared to the results of the initial audit. Other examples included audits for antipsychotic medicines; dementia screening and a blood levels that could lead to a severe thyroid condition which confirmed the GPs were providing clinical care in line with changes in clinical research and National Institute for Health and Care Excellence guidance. We also saw five audits were comparison audits between the Dunster and Porlock practices. GPs maintained records showing how they had evaluated the service and documented the success of any changes and shared this with all prescribers in the practice.

We saw evidence the practice was one of the highest prescribers locally for newer blood clotting medicines for patients with atrial fibrillation. The practice had changed the management of appropriate patients; utilised a risk stratification tool to guide their intention to review medicines and engaged with a local cardiologist to visit the practice and review these patients. We saw the actions were targeted towards improving patient outcomes.

This practice was not an outlier for any QOF (or other national) clinical targets from 2010-2012, It achieved between 98% and 100% of the total QOF target. From 2013 the practice had undertaken local reporting which reduced data reporting requirements meaning that comparative data was not available.

The team was making use of clinical audit tools, clinical supervision and staff meetings to assess the performance of clinical staff. The staff we spoke with discussed how, as a group, they reflected on the outcomes being achieved and areas where this could be improved. Staff spoke positively about the culture in the practice around audit and quality improvement, noting that there was an expectation all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also better than national figures. The practice was ranked number two out of 77 practices in the Somerset Clinical Commissioning Group for prescribing performance. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for patients with long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence that after receiving an alert, the GPs had reviewed the use of the medicine in question and, where they continued to prescribe it, outlined the reason why they decided this was necessary.

The practice had made use of the Gold Standards Framework for end of life care. It had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families.

The practice also kept a register of patients identified as being at high risk of admission to hospital and of those in various vulnerable groups for example, patients with learning disabilities and carers. Structured six monthly reviews were also undertaken for people with long term conditions.

In addition the practice used a risk profiling tool to identify patients who had a high risk of being admitted to hospital; overdue for screening or at risk because of their medicines.

The practice screened patients who were potentially at risk of diabetes. This included routine screening of a blood test (HbA1c) used to diagnose diabetes. Any patients found to have prediabetes were monitored six monthly. We saw evidence that a patient who had undergone blood tests was reviewed promptly by the nurse.

The practice participated in local benchmarking run by the Clinical Commissioning Group. This is a process of evaluating performance data from the practice and comparing it to similar surgeries in the area. This benchmarking data showed the practice had outcomes which were comparable or better than other services in the area.

Effective staffing

Practice staffing included medical, nursing, managerial, dispensary and administrative staff. We reviewed staff training records and saw all staff were up to date with attending mandatory courses such as annual basic life

support. We noted a good skill mix among the doctors with one having trained in public health medicine. The partners undertook lead roles locally and regionally within medicines management; GP performance, appraisal and revalidation; integrated health and social care implementation and the school of primary care. This showed us the GPs were actively involved in improving primary care.

All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook an annual appraisal that identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example, a nurse had received training to provide minor surgery. Another nurse had undertaken additional training about infection control and wound management. As the practice was a training practice, doctors who were training to be qualified as GPs were offered extended appointments and had access to a senior GP throughout the day for support. We received positive feedback from the trainees with whom we spoke with.

Practice nurses and health care assistants had job descriptions outlining their roles and responsibilities and provided evidence that they were trained appropriately to fulfil these duties. For example, in the administration of vaccines, cervical cytology and wound management. Those with extended roles for patients living with long term conditions including diabetes, asthma and chronic lung diseases were also able to demonstrate they had appropriate training to fulfil these roles.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out Of Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting upon any issues that arose from these communications. Out Of Hours reports, 111 reports and pathology results were all seen and actioned by a GP on the day they were received. Discharge summaries and letters from outpatients were usually seen and actioned on the day of receipt and all within two days of receipt. The GP who saw these documents and results was responsible for the action required. All staff we spoke with understood their roles and felt the system in place worked well. There were no instances identified within the last year of any results or discharge summaries that were not followed up.

Our data showed emergency hospital admission rates for the practice were relatively high at 16.3% compared to the national average of 13.6%. The practice was able to show us data that compared the practice with Porlock Medical Centre and local practices. This data showed emergency admission rates were low compared to other practices. The practice had a process in place to follow up patients discharged from hospital. In addition a new project with Age UK provides additional support which had been shown to reduce admissions.

The practice met monthly with multidisciplinary teams to discuss patients with complex needs. For example, those with mental health problems, people from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by health visitors, district nurses, palliative care nurses, mental health teams and decisions about care planning were documented in a shared care record. Staff felt this system worked well. Care plans were in place for nearly all patients with complex needs and shared with other health and social care workers as appropriate.

We spoke to the community mental health nurse and the health visitor. Both told us the GP's respected their views and assessments and acted upon the information, advice and suggestions given to them.

Information sharing

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

Outstanding ☆

Are services effective?

(for example, treatment is effective)

For patients who were referred to hospital in an emergency there was a policy of providing a printed copy of a summary record for the patient to take with them to Accident and Emergency. The practice had also signed up to the electronic Summary Care Record and planned to have this fully operational by 2015. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained to use the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. We saw evidence audits had been carried out to assess the completeness of these records and that action had been taken to address any shortcomings identified.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it. For some specific scenarios where capacity to make decisions was an issue for a patient, the practice had drawn up a policy to help staff. For example, with making do not attempt cardiopulmonary resuscitation orders. The policy also highlighted how patients should be supported to make their own decisions and how these should be documented in the medical notes.

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. Staff told us they were working with local care homes to have a care plan template that was the same for all organisations.

We saw meeting minutes from a meeting one GP attended with a local care home and the local authority safeguarding team around a patients mental capacity, advanced care plans and do not attempt cardiopulmonary resuscitation. The GP took part in a local initiative to improve integration between GPs and Independent Mental Capacity Advocates.

All clinical staff demonstrated a clear understanding of the Gillick competency test. (These are used to help assess whether a child under the age of 16 has the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a written consent form was completed and added into the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. All staff were clear about when to obtain written consent.

The practice had not needed to use restraint in the last three years, but staff were aware of the distinction between lawful and unlawful restraint.

Health promotion and prevention

The practice used information about the needs of the practice population identified by the Joint Strategic Needs Assessment (JSNA) undertaken by the local authority to help focus health promotion activity. The JSNA pulls together information about the health and social care needs of the local area.

It was practice policy to offer a GP appointment to all new patients registering with the practice. We noted a culture among the GPs to use their contact with patients to help maintain or improve mental, physical health and wellbeing. For example, by offering chlamydia screening to patients aged 18 to 25 years and offering smoking cessation advice to smokers.

The practice also offered NHS Health Checks to all its patients aged 40 to 75 years. Practice data showed 87% of patients in this age group took up the offer of the health check. We were shown the process for following up patients within two weeks if they had risk factors for disease identified at the health check and how further investigations were scheduled.

The practice had many ways of identifying patients who needed additional support, and it was pro-active in offering additional help. For example, the practice had identified the smoking status of 84% of patients over the age of 16. We saw the number of patients that attended nurse-led smoking cessation clinics was 25% above the national average. There was evidence these were having some success as the practice had a higher 'quit' rate of smoking

Outstanding ☆

Are services effective?

(for example, treatment is effective)

than other neighbouring practices. Similar mechanisms of identifying 'at risk' groups were used for patients who were obese and those receiving end of life care. These groups were offered further support in line with their needs. A dietician attended the practice monthly to provide nutritional health advice and management.

The practice's performance for the cervical screening programme was 79%, which was slightly below the national average of 81%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. We saw that 70% of patients had attended breast cancer screening which is above the West Somerset average of 68% and 63% of patients had attended bowel cancer screening which was above the West Somerset average of 58%.

The practice offered a full range of immunisations for children, travel vaccines and flu vaccinations in line with current national guidance. Last year's performance was above average for the majority of immunisations where comparative data was available. For example, flu vaccination rates for patients over 65 years were 70% which was slightly below national average. Childhood immunisation rates for the vaccinations given to under twos were 100% which was above the national and clinical commissioning group average.

One GP was involved with the faculty of public health medicine and had qualifications and experience in lead roles within public health medicine. We saw this led to high screening rates and high rates of health promotion advice.

The practice had been involved in sexual health training and clinics to students at the local college to promote good sexual health and to build a rapport with students so they felt able to come and talk to the clinical staff about concerns. The practice held a men's health event in 2014, arranged by the patient participation group which provided local men with advice about their health and wellbeing. We saw the agenda which included talks by the Police regarding alcohol safety; basic life support training; a talk by an urologist about prostate health; screening tests including blood pressure and cholesterol and healthy lifestyle advice.

The practice ran an annual flu day which included health promotion and screening tests.

The practice provided exercise via prescription and we saw evidence referrals were higher compared to other local practices. The practice was one of the first in the area to refer patients to 'Green Gym' which provided outdoor walking on Exmoor.

Outstanding ☆

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice about patient satisfaction. This included information from the national patient survey (March 2015); a survey of 139 patients undertaken by the practice's patient participation group (PPG) in November 2014 and NHS England Friends and Family Tests for February to April 2015. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

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

- 95% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 96% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 98% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 99% said the nurse gave them enough time compared to the CCG average of 95% and national average of 92%.
- 100% said the nurse was good at treating them with care and concern compared to the CCG average of 94% and national average of 90%

Patients completed Care Quality Commission comment cards to tell us what they thought about the practice. We received 29 completed cards and all were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. We also spoke with nine patients on the day of our inspection. They told us they were more than satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so confidential information was kept private. The practice switchboard was located away from the reception desk which helped keep patient information private. We saw patients could not overhear potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted it enabled confidentiality to be maintained.

Staff told us if they had any concerns or observed any instances of discriminatory behaviour or where patients' privacy and dignity was not being respected; they would raise these with the practice manager. The practice manager told us she would investigate these and any learning identified would be shared with staff.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour. Receptionists told us that referring to this had helped them diffuse potentially difficult situations. We were given two examples of aggressive patients. We saw a complaint made from an aggressive patient and saw that within the process staff had been given support for the impact the patient's behaviour had on them.

Currently the practice had limited accessibility due to the building. We saw evidence the plans for the new practice would make it easily accessible to all. Staff told us how they made sure patients with accessibility problems received care. For example, by changing consultation rooms or by providing home visits. Staff told us the practice was accessible to anyone. The patient participation group (PPG) reinforced what staff told us with regards to availability of home visits for patients with limited access. We saw staff ensured patients including those not registered at the practice were welcomed and provided with medical support and care.

One GP received a generous donation annually from a patient's family which they used to provide enhanced care to the local population. For example some money was used to fund night sitters to help patients stay at home with support. This funding was also accessible to people not

Are services caring?

registered at the practice. We saw staff were passionate about giving patients' good end of life care and had engaged in a project with Marie Curie to improve outcomes for patients with long term conditions.

Patients receiving end of life care had access to a GP via a mobile telephone. The practice operated this service to ensure continuity of care when the practice was closed.

A GP used his expertise to undertake procedures which were normally undertaken at the county hospital. An example was given of a patient who required a medical intervention not normally carried out by a GP.

The nurse told us they were able to call all 500 patients who attended the flu vaccination day by name. One GP told us about the feedback he received from patients about the nurses behaviours and attitudes. We were told they were well known and respected and the care they provided was compassionate and second to none. The PPG told us all staff were seen as part of the community and GPs would regularly engage in community activities and meetings in order to improve all local services for their patients.

We spoke to the community mental health team who told us staff treated patients with a great deal of respect and dignity and allowed time for them. They also told us staff went above what was required of them to be helpful and meet their needs.

Care planning and involvement in decisions about car and treatment

The patient survey information we reviewed showed patients responded positively to questions about their involvement in planning and making decisions about their care and treatment and generally rated the practice well in these areas. For example:

- 94% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 90% and national average of 86%.
- 95% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 86% and national average of 81%.
- 100% said the last nurse they saw or spoke to was good at explaining tests and treatments compared to the CCG average of 93% and national average of 90%.
- 98% said the last nurse they saw or spoke to was good at involving them in decisions about their care compared to the CCG average of 89% and national average of 85%

Patients we spoke with on the day of our inspection told us health issues were discussed with them and they felt involved in decision making about the care and treatment they received. They 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 translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patents this service was available.

The practice had recently started a pilot project with Age UK where volunteers would visit patients with two or more long term conditions to offer a befriending service and build a life plan. The practice had also involved a practice nurse from another surgery who would provide assistance with creating personalised care plans for these patients. We saw all patients with long term conditions had a personal management plan.

The practiced used 'You're Welcome' to enable a young people friendly service. University students were always welcomed back to the practice during holidays and any young person in the local area was able to attend the practice for health advice.

Patient/carer support to cope emotionally with care and treatment

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

• 96% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 89% and national average of 85%.

• 100% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 94% and national average of 90%.

Outstanding ☆

Are services caring?

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

Notices in the patient waiting room and patient website also told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them.

Staff told us that if families suffered bereavement, their usual GP contacted them. This call was either followed by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice about how to find a support service. GPs provided a direct contact number for patients receiving end of life care or those requiring extra medical support so they could have continuity of care in the evenings and weekends.

A carer's support group and a local advice bureau attended the practice monthly. A receptionist undertook a carer's champion role. Staff proactively identified carers and referred them to the carers support group. This included house bound patients where staff would refer them for a home visit.

Patients with long term conditions were given longer appointments of 40 minutes due to the complexity of their conditions which included routine questions around anxiety and depression. Housebound patients were visited by the nurses who undertook six monthly reviews.

The practice employed a home support nurse to support older people in their own home. The nurse told us that a large number of the patients visited were isolated and that she was able to provide them with additional support to cope with physical and emotional needs.

The practice had a patient booklet, 'if only I had known that' which listed support groups and voluntary agencies for example a group that provided patient transport for hospital appointments.

We saw patients' emotional and social needs were seen to be as important as their physical needs. For example the Age UK project and the role of the home support nurse.

One GP told us about a cancer patient who was too exhausted to attend an appointment with his oncologist. The GP arranged a telephone consultation with the patient, the oncologist and himself at the practice. They were able to look at the scan results via the computer as the oncologist discussed them and undertook blood tests in preparation for chemotherapy.

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered. For example the practice had included the patient participation group (PPG) in the decisions for the new surgery such as in choosing the facilities. The practice had responded to the 12 week road closure and implemented a satellite service in a community building and engaged the PPG to provide patients with refreshments; transport and prescription pick-up and delivery.

The NHS England Area Team and Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. Both partners undertook additional roles within these organisations.

The practice received a yearly practice profile from the Public Health team at the Local Authority which provided an overview of demographic, health and service use data at a practice level and compared to the CCG. This information was used to help focus services offered by the practice.

The practice had also implemented suggestions for improvements and made changes to the way it delivered services in response to feedback from the patient participation group (PPG).

The practice had implemented a number of projects based on patient demographics and with an aim to increase the quality of care delivered. Each year one partner received a large donation from a family following the end of life care he provided to a patient. The GP used the money to provide enhanced care to the local population which included funding for night sitters and providing end of life care training to carers. In addition, other practices in the area were able to access the night sitter service.

The practice employed a home support nurse to support older people (with an emphasis on the top 2% at risk of admission to hospital or those in greatest need, for example end of life care) in their own homes. The nurse worked within the multi-disciplinary teams, attending meetings to discuss patients' needs and visiting patients at home providing support and assessments. We spoke to the nurse who told us the role made life easier and more comfortable for those patients who were often vulnerable and isolated. For example, as a result of her visit one patient who was isolated now received support from 'village agents' who took the patient out. The nurse told us her role had reduced isolation and anxiety which in turn had reduced telephone calls to the practice and NHS 111 however the GP's were always responsive to need and would visit a patient within one hour if requested.

The practice had recently started a project with Age Concern (based on an existing successful project run in the South West which reduced hospital admissions) to improve lives of isolated elderly patients with more than one chronic illness and encourage them to maintain active healthy living. The practice home support nurse was involved with this project.

In 2014 the practice (as part of a local GP federation) and in conjunction with the patient participation group (PPG) ran a men's health event which provided health screening, health promotion advice and basic life support training. The event included the Police giving advice about managing traffic accidents and the hospital urology nurse talking about prostate health. The practice run a flu day annually. The PPG and staff described this as a large social event attracting 400 people. The event was inclusive of people in the village who were registered with another GP and included other community organisations such as carers support, the Police and energy firms.

We saw other examples of the practice being responsive to patient needs for example, working with the local college when education staff raised concerns around sexualised behaviour. The practice provided six monthly face to face reviews (with extended appointment times) for all patients with long term conditions when they were also screened for anxiety and depression. We saw this had resulted in a low acute admission rate to hospital within the Somerset area. We were told of examples of clinical staff undertaking clinical procedures that would normally be done within a hospital in order to provide more holistic care. The practice worked with local hospital consultants to provide additional clinics between the two practices. For example, a cardiac and a diabetes hospital consultant had attended

the practice to hold clinics. We saw that the practice engaged with the specialist end of life care team who supported the additional service provision provided by the practice.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, flexible or longer appointment times were available for patients with chronic diseases, older persons and patients with a learning disability. The practice had a carer's champion who liaised and made referrals to a local carers support group that visited the practice monthly.

The majority of the practice population were English speaking patients but access to online and telephone translation services were available if they were needed.

Staff were aware of when a patient may require an advocate to support them and there was information about advocacy services available for patients.

The practice had limited accessibility to patients with mobility difficulties. The practice was aware of this and had spent five years seeking planning permission for a new surgery where the premises and services had been designed to meet the needs of people with disabilities. GPs carried out home visits to any patient that had difficulty accessing the service.

Staff told us they did not have any patients who were of "no fixed abode" but would see someone if they came to the practice asking to be seen and would register the patient so they could access services. There was a system for flagging vulnerability in individual patient records. The practice was located in a popular tourist location and we were told any temporary residents were always accommodated.

There were male and female GPs in the practice; therefore patients could choose to see a male or female doctor.

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

The practice provided a service that allowed isolated patients or those with mobility difficulties to collect repeat medicines from local village stores.

Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday except Thursday when the practice closed at 12:30. Porlock Medical Centre covered the practice on Thursday afternoons. Appointments were available from 08:10 to 11:00 Monday to Friday and 16:00 to 18:00 (except Thursdays). Early morning appointments were available if patients requested. Urgent appointments were available daily and any children were always provided with an on the day appointment. Young people from any local practice could sit and wait to be seen. Telephone appointments were available twice daily. Dietician, chiropody and counselling appointments were available.

Comprehensive information was available to patients about appointments on the practice website. This included how to arrange urgent appointments and home visits and how to book appointments through the website. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed. If patients called the practice when it was closed, the call was diverted to NHS 111. Information about the Out Of Hours service was provided to patients.

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

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

- 80% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 88% described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 80% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70% and national average of 65%.
- 99% said they could get through easily to the surgery by phone compared to the CCG average of 79% and national average of 73%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They

Outstanding ☆

Are services responsive to people's needs?

(for example, to feedback?)

confirmed they could see a doctor on the same day if they felt their need was urgent although this might not be their GP of choice. They also said they could see another doctor if there was a wait to see the GP of their choice. Routine appointments were available for booking in advance. Patients told us reception staff always made sure that they could get them an appointment on the day they wanted to be seen.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaint policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice. The practice had a process that when a complaint was about a GP partner, the other partner would take a lead role in the investigation.

We saw information was available to help patients understand the complaint system in the practice, practice leaflet and practice website. The practice also provided a comments box in the waiting room and on the website. 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 ever needed to make a complaint about the practice.

We looked at the one complaint received in the last 12 months and found the quality of recording and investigation to be satisfactory. We saw NHS England had also undertaken an overview of the complaint and the GP it concerned. We found the response from the practice to be open and transparent with the appropriate level of apology and options given to the patient and family.

We saw lessons learnt from individual complaints had been acted upon and the complaint discussed at a practice meeting.

Are services well-led?

Outstanding ☆

(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; promote good outcomes for patients; focus on prevention of disease by promoting healthy living and actively involving and encouraging patients to participate in their health management. We found details of the vision and practice values were part of the practice's business plan. We saw evidence the business plan was regularly reviewed by the practice. The practice strategy was linked to NHS England's top ten priorities to improve quality and care. For example we saw the practice provided dietician appointments to help patients manage obesity and prevent diabetes.

We spoke with four members of staff and they all knew and understood the vision and values of the practice and knew what their responsibilities were in relation to these and had been involved in developing them. They told us the practice values meant that the patient was always the priority. We looked at minutes of the practice meetings and saw staff had discussed the strategy for the business.

We saw that the vision for the practice was challenging and innovative. For example the practice was currently in the process of amalgamating with a local practice that was closing which would result in an additional 1700 patients.

Governance arrangements

Governance arrangements including the practice manager role were shared with Porlock Medical Centre.

The practice had a number of policies and procedures in place to govern activity and these were available to staff on the desktop on any computer within the practice. We looked at five of these policies and procedures and confirmed staff had read the policy. All five policies and procedures we looked at had been reviewed annually and were up to date.

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

The GPs and practice manager took an active leadership role for overseeing the systems in place to monitor the quality of the service were consistently being used and were effective. In 2014 GP practices within Somerset Clinical Commissioning Group undertook SPQS (Somerset Quality Practice Scheme), a local alternative to the national GP quality incentive scheme (QOF) which financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. SPQS was introduced to assist practices to align their care with local priorities and to be more effective in helping those patients with complex needs.

The data for this practice showed it was consistently performing above national standards for managing some of the most common long-term conditions achieving 100% in many clinical areas and for the implementation of preventative measures. We saw SPQS data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. We saw three audits and evidence that 14 additional in-depth audits had been undertaken in the past three years. These included audits that compared findings between the two practices, for example, one audit compared the management of patients after heart attacks between the two practices and another the prescribing of antipsychotic medicines which were both done in line with NICE guidance. In addition the practice used Eclipse Live, a risk profiling tool which alerted the practice to patients put at risk due to medicines. Evidence from other data sources, including patient safety alerts; clinical research; incidents and complaints was used to identify areas where audits could be undertaken and improvements could be made.

Additionally, there were processes in place to review patient satisfaction and that action had been taken, when appropriate, in response to feedback from patients or staff. The patient participation group (PPG) told us the practice leaders proactively engaged with them around practice performance and quality improvement. We saw the practice received an annual practice profile from Public Health England which they used with the PPG to target priority areas that required improvement.

Are services well-led?

Outstanding ☆

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

The practice regularly submitted governance and performance data to the CCG. CCG data was used by the practice to measure their performance with Porlock Medical Centre and other practices within the local area.

The practice identified, recorded and managed risks. It had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example when a member of staff was pregnant. The practice monitored risks on a monthly basis to identify any areas that needed addressing. There was a programme for annual risks assessments to ensure the practice was meeting requirements. For example, a building risk assessment and identification of risks associated with the Control of Substances Hazardous to Health (COSHH Regulations 2002).

The practice held monthly staff meetings where governance issues were discussed. We looked at minutes from these meetings and found that performance, quality and risks had been discussed.

The practice manager was responsible for human resource policies and procedures. We saw a number of policies, (for example disciplinary procedures, induction policy, and management of sickness) which were in place to support staff. We were shown the electronic staff handbook that was available to all staff, which included sections about health and safety; equality and harassment and bullying at work. Staff we spoke with knew where to find these policies if required. The practice had a whistleblowing policy which was also available to all staff on any computer within the practice.

Leadership, openness and transparency

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

We saw from minutes that practice meetings were held every month. Staff told us there was an open culture within the practice and information sharing was actively encouraged. Staff had the opportunity to raise any issues at any time, were confident in doing so and felt supported if they did. We also noted the practice meetings had a standing agenda item to discuss the vision and strategy for the business. All staff we spoke with felt respected, valued and supported, particularly by the partners in the practice who they described as amenable and approachable. Staff told us the partners often gave them positive feedback

Both partners undertook lead roles outside the practice such as a chairperson of the local GP Federation; lead for the local implementation group for integrated health and social care; a role with NHS England and one with the Local Medical Committee. Staff told us these roles helped the practice enhance the quality of care and provided a network of contacts for a small rural practice.

A succession plan was in place to ensure continued leadership as the practice recognised the link with good performance.

Seeking and acting on feedback from patients, public and staff

The practice encouraged and valued feedback from patients. It had gathered feedback from patients through the patient participation group (PPG), surveys, suggestion box and complaints received. It had an active PPG which included representatives from various population groups; for example a member who had caring responsibilities for a patient with dementia and patients of working age. We saw the analysis of the last patient survey, which was considered in conjunction with the PPG. The results and actions agreed from these surveys were available on the practice website. The PPG were encouraged to attend practice meetings and told us their suggestions resulted in change. For example, the practice was considering taking on responsibility for provision of services when a local practice closes. The PPG were actively involved in discussions and the practice welcomed constructive challenges from the group about the staffing and facilities provision. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We spoke with five members of the PPG and they were very positive about the role they played and told us they felt engaged with the practice. The PPG were encouraged to attend practice meetings and told us their suggestions resulted in change. When the practice used a community building when the main road was closed for 12 weeks, the PPG were involved in providing refreshments for patients; picking up laboratory samples from patients and delivering prescriptions. The PPG were also involved in the planning

Are services well-led?

Outstanding ☆

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

for the new surgery which included attending public meetings; planning of the facilities and discussions around taking on responsibility for the provision of services of a local GP practice that was closing. When recruitment for a new GP took place the PPG were fully engaged and included within the process. Patients through the PPG were given a majority decision on the selection of the GP. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

We also saw evidence the practice had reviewed its' results from the national GP survey to see if there were any areas that needed addressing. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

There was an open culture within the practice and staff were actively encouraged to raise concerns and suggestions for improvement. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. We saw high levels of staff satisfaction. Staff told us they were proud of the organisation and the care patients received.

Staff told us that their requests for specific training had always been approved. One nurse told us about the recent stress management course for practice nurses which she had requested and attended. Staff told us they felt involved and engaged in the practice to improve the quality of care for patients. For example, one nurse had undertaken training with a specialist hospital consultant to improve the care given to patients with skin and hair problems.

We were told about arrangements the practice made for the hospital consultant for older people and a cardiologist to attend the practice to reduce the impact of a rural community having to travel to appointments. We were told about a patient with cancer who was too unwell to travel 60 miles to see a specialist. The GP arranged for the specialist to telephone the patient at the practice. The nurses worked closely with clinical experts at the local hospital for example the diabetic specialist nurse attended diabetic education groups the nurse organised and the practice nurses would attend consultations between the respiratory consultant and patient to ensure continuity of care.

The practice organised a flu clinic day annually in the village. The day included representatives from other community services such as the Police, Age Concern, energy companies and carer support groups. To meet the needs of the local community the day was open to all members of the community including those patients not registered with the practice.

Management lead through learning and improvement

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

The practice was a GP training practice. We spoke to the GP registrar who told us the practice set high standards of evidence based care and managed to ensure care was personalised and patient centred. They told us clinical staff had good knowledge of family histories and patient illness.

We saw a systematic approach was taken to working with other organisations to improve care outcomes, tackle health inequalities and obtain best value for money. For example the Age Concern project and the employment of the home support nurse who worked with voluntary agencies. We also saw that the practice learnt from and improved services as a result of projects undertaken at the sister practice. For example work with NICE around new QOF measurements. As a result the practice had implemented changes to improve the quality of care provided.

We were told there was a culture of learning for all clinical staff for example, we saw evidence the practice valued GP trainees and had changed their own practice in order to improve quality. For example nurses would cascade information learnt on training days and updates to national guidance to all practice staff in practice meetings; GPs provided training sessions, for example one GP provided a session to all staff about kidney disease and blood test results were shared with other GP's if knowledge of the results could impact on care or there was a learning opportunity from the results.

The GPs actively engaged with hospital consultants to review care. One GP had arranged for an oncologist to hold a teleconference with a patient and the GP. The GP told us about that this had ensured the patient received the best

Are services well-led?

Outstanding ☆

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

care available without having to travel when unwell. They also told us about the improvement in knowledge in cancer treatment and the increased understanding of results from investigations they had gained as a result.

We saw the practice had been involved in pilot projects for example the Age Concern project. We also saw the practice responded to project work undertaken at the sister practice. For example a project with NICE around quality outcomes and as a result the practice had implemented changes to improve the quality of care provided.

The practice had completed reviews of significant events and other incidents and shared the findings with staff at meetings to ensure the practice improved outcomes for patients. For example, a patient had been discharged from hospital and the discharge letter had not arrived. The patient's family had provided a copy of their discharge letter which was not added to the medical records until after the GP had prescribed medicines. We saw a root cause analysis had been undertaken, all staff had been involved in a discussion and an action plan around the lessons learnt was completed.

This section is primarily information for the provider

Enforcement actions

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.