Axbridge & Wedmore Medical Practice

Quality Report

Axbridge and Wedmore Medical Practice
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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	Requires improvement
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	Requires improvement

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Axbridge and Wedmore Medical Practice on 5 May 2015. Overall the practice is rated as requires improvement.

Specifically, we found the practice be rated as good for providing effective, caring and responsive services but requires improvement for providing safe and well led services. It was also rated as requires improvement for providing services for the population groups.

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. Opportunities for learning from internal and external incidents were maximised.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example, participation in research projects.
- Staff were supported with training and career development.
- Patients said 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 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 facilities were well equipped to treat patients and meet their needs.
- Information about how to complain was available and easy to understand.

Summary of findings

- There were areas of practice where the provider needs to make improvements in how they monitor and assess the quality of the services provided and ensure protocols and processes were fully implemented.
- We found there was no overall maintenance programme for the practice and areas were in need of repair and redecoration.
- The cleanliness and infection control practices needed to improve so the practice was clean.
- We also found that staff attended training but how this was applied into working practice had not been evaluated. Some staff had not attended training appropriate to their role.

We saw several areas of outstanding practice including:

- The practice is part of the North Sedgemoor Federation which funds a Somerset Village Agent, a project which was initiated in 2014 and is funded until 2016. The project uses paid, part time, highly trained individuals living in the parish 'clusters' they support. They help to bridge the gap between socially isolated, excluded, vulnerable and lonely individuals and statutory and/or voluntary organisations which offer specific solutions to identified needs.
- The practice had set up an independent charitable 'Community Health Fund' which was used in a variety of ways to support patients registered at the practice. For example, money from the fund was used to purchase training for carers registered at the practice from the Alzheimer's Society.

However there were areas of practice where the provider needs to make improvements.

The areas where the provider must make improvements are:

- Ensure there is a building maintenance programme in place.
- Undertake regular risk assessments of the environment to identify any risks to patients' safety.
- Ensure the cleaning schedule is effective to maintain the premises so they are clean and hygienic.
- Review protocols in place for patient safety and ensure staff are able to put them into practice such as emergency protocols, cold chain protocols, safeguarding protocols.
- Fully implement the recruitment policy so there is evidence that patients are protected from the risk of the employment of unsuitable staff.
- Ensure staff are appropriately trained for the roles they fulfil such as vaccinations.

In addition the provider should:

- Undertake a risk assessment for the siting of emergency medicines and equipment so they are easily accessed in an emergency.

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?

Requires improvement

The practice is rated as requires improvement for providing safe services. Staff understood and fulfilled their responsibilities to raise concerns and report incidents and near misses. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. We found the practice used opportunities to learn from internal and external incidents, to support improvement. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. We found the arrangements for the implementation of safe practices such as infection control and cleanliness and maintenance of the buildings required improvement. There were no environmental risk assessments in place. The practice had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that 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 that these guidelines were positively influencing and improving practice and outcomes for patients. The practice undertook clinical audits to evaluate the effectiveness of prescribed treatment. We found staff had the skills, knowledge and experience to deliver care and treatment and had undertaken additional training to support this.

Are services caring?

Good

The practice is rated as good for providing caring services. We observed a strong patient-centred culture. Patients' feedback about the practice said they were treated with kindness, dignity, respect and compassion while they received care and treatment. Patients told us they were treated as individuals and partners in their care. We found the practice routinely identified patients with caring responsibilities and supported them in their role. Patients told us their appointment time was always as long as was needed, there was no time pressure, and patients were reassured that their emotional needs were listened to empathetically.

Summary of findings

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient participation group (PPG). It reviewed the needs of its local population and engaged with the NHS England Area Team and Somerset Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. We found urgent and routine appointments were available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Requires improvement

The practice is rated as requires improvement for being well-led. The practice had a vision with quality and safety as its top priority. The leadership structure was going through a period of change; we found that staff training was not embedded into practice. The systems in place to support the day to day running of the practice were not always reviewed to demonstrate quality improvement and mitigate risk. Governance arrangements were in place and the practice carried out proactive succession planning. The practice gathered feedback from patients using new technology, and had a virtual patient participation group (PPG).

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

Requires improvement

The practice is rated as requires improvement for the care of older people. The provider was rated as good for caring, responsive and effective services but requires improvement for safe and well led services. The concerns which led to these ratings applied to everyone using the practice, including this population group.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, emergency admission avoidance. Patients over 75 had a named GP. We found integrated working arrangements with community teams. The practice worked closely with carers and two staff members acted as carers champions.

People with long term conditions

Requires improvement

The practice is rated as requires improvement for the care of people with long-term conditions. The provider was rated as good for caring, responsive and effective services but requires improvement for safe and well led services. The concerns which led to these ratings applied to everyone using the practice, including this population group. Nursing staff had lead roles in chronic disease management. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly nurse led clinics were available to patients diagnosed with diabetes. Patients at risk of hospital admission were identified as a priority for appointments. Longer appointments and home visits were available when needed. All of these patients had a structured annual review to check their health and medicines needs were being met. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choice with other service providers.

Families, children and young people

Requires improvement

The practice is rated as requires improvement for the care of families, children and young people. The provider was rated as good for caring, responsive and effective services but requires improvement for safe and well led services. The concerns which led to these ratings applied to everyone using the practice, including

Summary of findings

this population group. 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.

Working age people (including those recently retired and students)

Requires improvement

The practice is rated as requires improvement for the care of working-age people (including those recently retired and students). The provider was rated as good for caring, responsive and effective services but requires improvement for safe and well led services. The concerns which led to these ratings applied to everyone using the practice, including this population group.The needs of the working age population, those recently retired and students had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. The practice was proactive in offering online services as well as a full range of health promotion and screening that reflects the needs for this age group. The practice offered extended hours, weekend appointments and telephone consultations.

People whose circumstances may make them vulnerable

Requires improvement

The practice is rated as requires improvement for the care of people whose circumstances may make them vulnerable. The provider was rated as good for caring, responsive and effective services but requires improvement for safe and well led services. The concerns which led to these ratings applied to everyone using the practice, including this population group. The practice supported referrals to the local food bank. They held a register of patients such as those with a learning disability. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding 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)

Requires improvement

The practice is rated as requires improvement for the care of people experiencing poor mental health (including people with dementia). The provider was rated as good for caring, responsive and effective services but requires improvement for safe and well led services. The concerns which led to these ratings applied to everyone using the practice, including this population group. The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. Patients could access mental health support services at

the practice. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as talking therapies. The practice undertook the enhanced service for facilitating timely diagnosis and support for people with Dementia and contributed funding to a Dementia Café. They had also, through their health fund, arranged for training for carers registered with the practice from the Alzheimer's Society.

Summary of findings

What people who use the service say

We spoke with three patients visiting the practice and we received 14 comment cards from patients who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey.

The comments made by patients were very positive and praised the care and treatment they received. For example, patients had commented about being involved in the care and treatment provided. We had heard anecdotal evidence prior to inspection from patients who had experienced delays in accessing routine appointments with a GP of their choice. However this was not reflected either by patients who spoke with us or by the completed comment cards.

The practice had a virtual patient representation group (PRG), the gender and ethnicity of the group was representative of the total practice patient population. Information about the group was available on the website and in the practice. We spoke with patients who had been involved with the patient consultation groups who told us they worked with the practice for service improvement.

The practice had also commenced their current 'friends and family' survey. We saw the commentary responses from patients which included observations such as efficient and friendly, staff always have time to listen and patients are never hurried through their appointments.

Areas for improvement

Action the service MUST take to improve

- Ensure there is a building maintenance programme in place.
- Undertake regular risk assessments of the environment to identify any risks to patients' safety.
- Ensure the cleaning schedule is effective to maintain the premises are clean and hygienic.
- Review protocols in place for patient safety and ensure staff are able to put them into practice i.e. emergency protocols, cold chain protocols, safeguarding protocols.
- Fully implement the recruitment policy so there is evidence that patients are protected from the risk of the employment of unsuitable staff.
- Ensure staff are appropriately trained for the roles they fulfil i.e. vaccination.

Action the service SHOULD take to improve

- Undertake a risk assessment for the siting of emergency medicines and equipment so they are easily accessed in an emergency.

Outstanding practice

- The practice is part of the North Sedgemoor Federation which funds a Somerset Village Agent, a project which was initiated in 2014 and is funded until 2016. The project uses paid, part time, highly trained individuals living in the parish 'clusters' they support. They help to bridge the gap between socially isolated, excluded, vulnerable and lonely individuals and statutory and/or voluntary organisations which offer specific solutions to identified needs.
- The practice had set up an independent charitable 'Health Fund' which was used in a variety of ways to

support patients registered at the practice. For example, money from the fund was used to purchase training for carers registered at the practice from the Alzheimer's Society.

Axbridge & Wedmore Medical Practice

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 and a nurse specialist advisor.

Background to Axbridge & Wedmore Medical Practice

Axbridge and Wedmore Medical Practice are located in a rural area of Somerset. They have approximately 8616 patients registered who are of a White British ethnicity.

The practice operates from two locations:

Axbridge Surgery

Houlgate Way

Axbridge BS26 2BJ

And

Wedmore Surgery

St. Medard Road

Wedmore BS28 4AN

The practice is made up of five GP partners and three salaried GPs working alongside qualified nurses and health care assistants who work at both locations. The practice has a general medical service contract and also has some additional enhanced services such as unplanned admission avoidance. The Axbridge Surgery is open Monday – Friday, 8am - 6.30pm and Wedmore Surgery Monday & Friday 8am - 6.30pm, Tuesday, Wednesday and Thursday 8am-1.00pm. Extended hours with pre-bookable appointments are available on Wednesday and Thursday 6.30pm - 8pm at Axbridge Surgery on alternate weeks; and at the Wedmore Surgery on Wednesday and Thursday 7am - 8am once a month, and Saturday 8am - 9.30am on alternate weeks.

The practice does not provide out of hour's services to its patients, this is provided by South West Ambulance Service Trust. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years old: 3.9%

5-14 years old: 12.6%

Under 18 years: 17%

65-74 years old: 21.2%

75-84 years old: 8.2%

85+ years old: 2.2%

Information from NHS England indicates the practice is in an area of low deprivation with a lower than national average number of patients with long standing health conditions, a higher than average number of patients with caring responsibilities and high levels of employment. The patient gender distribution was male 49.5% and female 50.5%.

The practice does not participate in the national quality and outcomes framework but is part of the Somerset Practice Quality Scheme. The practice has Wi-Fi at both sites for patients to access.

Detailed findings

Why we carried out this inspection

We inspected this service as part of our new comprehensive inspection programme under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2015, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 5 May 2015 and visited both sites. During our visit we spoke with patients, a range of staff including GPs, nurses, reception and administrative staff and the management team, and spoke with patients who used the service. We observed how people were being cared for and talked with carers and/or family members and reviewed anonymised treatment records of patients.

The team spent time at both sites; we reviewed the premises and observed the day to day running of the sites.

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

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

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

Requires improvement

Are services safe?

Our findings

Safe track record.

The practice had systems in place for the safety of patients and staff who worked at the service. We saw records of training which indicated staff had been updated to understand and implement the latest guidance for treatment such as how to deal with anaphylaxis. We spoke with three GPs and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about three incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. Where changes in practice had been highlighted we were able to confirm they had been implemented. When events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to Somerset Social Services. National patient safety alerts and other safety guidance was checked and circulated to the relevant staff.

The practice manager told us how comments and complaints received from patients were responded to. Staff we spoke to were aware of their responsibilities to raise concerns, and how to report incidents or events. We were told about the open culture in which staff felt they were listened to and responded to in a way which promoted learning rather than blame. We read minutes of meetings which evidenced that the above information was recorded and reviewed by the partners at the practice.

Learning and improvement from safety incidents.

There was a range of systems in place for recording incidents and taking appropriate action to improve systems and processes so that further incidents were prevented. For example, the practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role.

We saw from summaries of the analysis of these events and complaints which had been received that the practice put actions in place in order to minimise or prevent reoccurrence of events. For example, where an issue of practitioner competence had occurred, the GPs discussed what actions had been taken, and should the issue arise again what could be done differently.

Staff reiterated to us that promoting and improving the service for patients was their primary concern. We were told how all staff were encouraged to participate in learning and to improve safety as much as possible and this meant they were confident to report concerns when things went wrong. For example, we found significant event and complaints were reported by both administrative and clinical staff.

We also looked at accident and complaint records and saw that incidents had been recorded and if needed escalated to significant events which demonstrated the practice listened and had the intent to learn and make improvements. Safety alerts and information relating to patients was available on the electronic records for staff to readily access.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We asked members of medical, nursing and administrative staff about their most recent training. We were told that all non-clinical staff at the practice had been provided with training for both safeguarding vulnerable adults and children. One GP took the lead with safeguarding at the practice. All of the GPs had been trained to level three for the safeguarding of children.

There are comprehensive systems to keep people safe, which took account of current best practice. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities to report any concerns. We saw there was information around the practice on how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Staff we spoke to were not all aware who the lead person was for safeguarding adults and children, but would speak to the practice manager if they had a safeguarding concern.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with

partner agencies such as the police and social services and they participated in multi-agency working. Regular discussions took place with health visitors in regard to children identified as at risk.

A proactive approach to anticipating and managing risks to patients was recognised as the responsibility of all staff. There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments for example, children who were subject to child protection plans. We asked how information from the out of hours GP service or 111 service was received into the practice. We were told that this was electronically but there was no formal system in place to ensure the information was reviewed in a timely way.

There was a chaperone policy, which was visible on the waiting room and in consulting rooms. There was a chaperone protocol for staff which set out clear steps staff should take and how chaperone support should be recorded in patient's records. The nursing staff who gave chaperone support to patients told us they had not received specific training for this. Patients told us they were aware of the availability of chaperones if they required it.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a protocol for ensuring medicines were kept at the required temperatures as we saw evidence the temperatures of refrigerators were recorded daily. However, we read that the refrigerator had been recorded at 10 degrees for three weeks but staff could not tell us what action was taken as a result of this potential failure. We ensured the medicines stored in the refrigerator were unaffected by this. The lead nurse could not provide us with a cold chain protocol however the practice manager had a copy of the Public Health England 'Protocol for ordering, storing and handling vaccines'.

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. The practice had identified items which were due to expire in the next three months, and checked the medicines monthly. Expired and unwanted medicines were disposed of in line with waste regulations.

The practice had a GP who was the prescribing lead and they were also supported by the Somerset Clinical Commissioning Group pharmacist. We saw records which noted the actions taken in response to a review of prescribing data. For example, ensuring prescribing for patients with chronic obstructive pulmonary disease met best practice and National Institute for Health and Care Excellence guidance.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of both sets of directions and evidence that trained nurses had received appropriate training to administer vaccines. However, one member of the nursing team who administered vaccines had trained as a qualified nurse but employed as a healthcare assistant and was no longer on the Nursing and Midwifery Council and had been on the register for several years but had not received any specific training.

There was a system in place for the management of high risk medicines, which included regular monitoring, that followed the national guidance. We found appropriate action was taken based on the results.

Blank prescription forms were handled in accordance with national guidance as these were tracked through the practice and kept securely. There was a protocol for repeat prescribing which followed the national guidance and implemented in practice. The protocol complied with the legal framework and covered all required areas. For example, how staff who generated prescriptions were trained and how changes to patients' repeat medicines were managed. Staff told us this helped to ensure that patients' repeat prescriptions were still appropriate and necessary. This was overseen by the GPs so that they would be aware of any discrepancies and changes to medicines. We were told when patients were discharged from hospital the scanned document was then sent to the appropriate GP for checking and authorisation of any medicine changes.

Cleanliness and infection control

We visited both sites and observed the premises dirty in places with layers of dust, unemptied bins and generally

poor standards of cleanliness. We observed the carpets in some consultation rooms were badly marked and needed cleaning. At Wedmore Practice the ceiling vents were rusted and extractor fans clogged with dust. We saw there were cleaning schedules in place and cleaning records were kept. However, cleaning equipment was found to be dirty, for example, some mop heads were dirty and stood in dirty water. The only sink the cleaners had access to was the staff kitchen sink in both premises. We saw the covering of some examination couches was split and presented an infection control risk. The practice manager stated that new couches were on order and that immediate action would be taken in respect of the cleanliness of the premises.

The practice lead nurse had responsibility for infection control. They had undertaken an audit based on the Somerset Clinical Commissioning Group guidance. We found not all staff received induction training about infection control specific to their role but received regular updates. We saw evidence the practice audit had identified improvements which were actioned. The practice had an identified isolation area to direct patients to who may be a public health risk.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the storage and use of personal protective equipment including disposable gloves, aprons and coverings. We also saw records were kept of staff training and updates, and immunisation status. The protocols 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 guidance. For example, when carrying out intimate patient examinations or taking blood samples. There was also a protocol to follow in the event of a needle stick injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. We found evidence staff had recently completed a hand washing exercise to promote effective hand washing. Waste bins were foot operated in clinical areas to maintain hygiene standards, however not all bins in the patient toilets were foot operated as recommended.

Staff were able to tell us about and show us the systems for safe disposal of clinical waste. The practice had a suitable contract with a clinical waste company.

The practice had a policy for the management, testing and investigation of legionella (a bacterium that can grow in contaminated water and can be potentially fatal).We saw documentation indicating the most recent water test was 2013, however records for the practice confirmed regular checks were carried out according to the premises' legionella assessment, which reduced the risk of infection to staff and patients.

Equipment

The practice at Axbridge was suitably designed and adequately equipped. The practice at Wedmore was in an old cottage which had been adapted within its constraints as a GP surgery. The buildings, fixtures and fittings were owned by the practice who employed specialist contractors as needed. There was no formal ongoing maintenance for the building which appeared tired, and particularly at the Wedmore practice, in need of redecoration. For example, the front door to the building had peeling paint and exposed wood. We observed there was direct access from the Wedmore practice onto a road and exposed radiator valves in a consultation room. We were told no risk assessments had been carried out in respect of either of the premises.

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date. A schedule of testing was in place. The practice had a contract for the calibration of relevant equipment; for example weighing scales, spirometers, blood pressure measuring devices and the fridge thermometer.

Other equipment such as fire extinguishers were also serviced and tested annually according to fire safety requirements. Fire alarms and emergency lighting were also regularly tested and serviced to meet the recommendations for fire safety. The security alarm was also tested annually.

Requires improvement

Are services safe?

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms to aid less mobile patients to stand; all appeared in safe condition although not all had a washable covering as recommended. Adjustable examination couches were available in all treatment rooms which had appropriate privacy screening.

Staffing and recruitment

The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at employee files for the most recent recruits to confirm this had been implemented. We were able to see for one person who was going through the recruitment process that the practice had implemented their policy. For example, proof of identification, references, qualifications, registration with the appropriate professional body and criminal records checks through the Disclosure and Barring Service (DBS). For another person who had started working at the practice there was no evidence of references. The practice manager stated they had taken telephone references but not recorded the conversation. When looking at the staff files we saw there was an induction checklist appropriate to the role of the staff member. Staff we spoke confirmed these had been used and that induction was as long as was needed for staff to feel confident in the role.

Staff told us about the arrangements for planning and monitoring the number of staff and mix of staff needed to meet patients' needs. We saw there was a rota system in place for all the different staffing groups to ensure that enough staff were on duty. There was also an arrangement in place for members of staff, including nursing and administrative staff, to cover each other's annual leave. The practice used GP locums when necessary, but kept them to a minimum, so as to ensure consistency of care.

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. This was reflected in the comments made by patients about the staff at the surgery. The IT manager showed us records to demonstrate that actual staffing levels and skill mix met with planned staffing requirements.

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; however these were not always fully implemented. There were no annual or monthly checks of the building which would identify if the environment was safe. The practice also had a health and safety policy and information file which identified key staff members for areas of responsibility. Unfortunately this was out of date and referred to staff who no longer worked at the practice. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Cleaning materials were stored separately but in unlocked cupboards which did not meet the Control of Substances Hazardous to Health (CoSHH) guidelines.

There were systems in place for monitoring higher risk patients such as those with long term conditions, in receipt of end of life care and patients being treated for cancer. Welfare, clinical risks and the risks to patient's wellbeing were discussed daily and weekly by the GPs and nursing staff. Patients who were identified as particularly vulnerable had a named GP and a care plan in place which specified potential problems and how the patient, in discussion with their GP, wished to be treated for them.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were told there was always first aid equipment available on site when the practice was open. We looked at the accident recording log book and found when accidents had occurred at the practice, they were recorded and appropriate action was taken to prevent recurrence.

The practice computer based records had an alert system in place which indicated which patients might be at risk of medical emergencies. This enabled practice staff to be alert to possible risks to patients. This information was shared with the reception team if patients were vulnerable. The staff we spoke with told us they knew which patients were vulnerable and how to support them in an emergency until a GP arrived.

Emergency medicines were also available in both practices and were routinely audited to ensure all items were fit for use. All staff had completed basic life support training and knew where emergency medicines and equipment were stored and how to use them, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. Processes were also in place to check whether emergency

Requires improvement

Are services safe?

medicines were within their expiry date and suitable for use. All the medicines we checked were in date and fit for use. We asked staff about who would respond to emergencies, the answers were inconsistent. The practice did not have a written protocol for this eventuality.

Emergency equipment available included oxygen and an automated external defibrillator. The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children. However we noted that emergency medicines and emergency equipment were not always stored together and this could mean a delay in treatment.

Urgent appointments were available each day both within the practice and for home visits. We were told that the practice prioritised requests for urgent appointments for children. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had not ever been refused access to a GP.

The practice had an alarm system within the computerised patient record and telephone system to summon help if needed. A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out. For example, contact details of the power supplier.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. A fire risk assessment had been undertaken that included actions required to maintain fire safety. We saw records that showed the system had been maintained and tested. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. 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 minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used an assessment tool aligned with professional knowledge of patients to identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid any crisis in their health. The practice used computerised tools to identify patients with complex needs and then ensured they had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients in this category who were recently discharged from hospital were reviewed within 72 hours. This was monitored by the staff on receipt of discharge summaries, who ensured they were followed up by the most appropriate staff member.

The patients we spoke with told us there was a holistic approach to assessing, planning and delivering care and treatment and we were given examples of how GPs and nurses involved them in their care and treatment. For example, patients told us they were always given treatment options and supported to make a decision on what would be most appropriate for them. We were told how the treatment they received helped them to get better or to maintain their health. 98% of patients involved in the most recent national GP patient survey said the GP was good at explaining things and involving them in their care which was above the local Clinical Commissioning Group average.

The GPs told us they had lead responsibility for specialist clinical areas and consultation between clinicians took place for a variety of conditions such as diabetes and heart disease to ensure best practice. The practice nurses supported this work and held specialist training qualifications in order to hold nurse led clinics. Clinical protocols were in place and had been adapted by the practice to add value to patient care. For example the asthma action plan given to all asthmatic patients was based on NICE guidance, the protocol included reviews and advice about managing their condition according to the latest guidance.

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

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. We were told the practice had opted out of the Quality Outcomes Framework (QOF) which is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewarded practices for managing some of the most common long-term conditions and for the implementation of preventative measures. Somerset introduced a local alternative to the national GP quality incentive scheme in 2014 which the practice had opted to be part of. The Somerset pilot is regarded by NHS England as an early pilot of co-commissioning arrangements and the practice had co-commissioned services such as the Village Agent who worked directly with patients. The Somerset pilot had three strands clinical care, integration projects and sustainability projects. The projects were intended to allow the development of new models, freeing up the innovation in general practice. A senior GP partner told us about the change of emphasis to the promotion of person-centred care focused on patient activation, patient outcome and patient experience. The practice had completed their data return for the pilot scheme and the result was due to be published in July 2015. This meant the practice had limited data available to demonstrate their performance.

The practice showed us clinical audits which had been undertaken in the last year. These were a range of

Good

Are services effective?

(for example, treatment is effective)

completed audits from which the practice was able to demonstrate the changes resulting since the initial audit. For example, we saw the practice had been involved in medicines audits which had ensure patients received medicines at the correct dosage for maximum efficacy.

The practice had participated in an integrated care clinic which provided specialist led care directly to patients in the practice. The programme concerned stroke prevention in atrial fibrillation and 102 patients participated in a review who had a CHADS2 (congestive heart failure (C), high blood pressure (H), age 75 or older (A), and diabetes (D), and two points for a previous stroke (S2) or transient ischemic attack) score of one or more, on anticoagulation therapy. Patients were invited to attend a clinic session which enabled them to be reviewed and attend an educational session about their diagnosis. The results of the sessions were that 81% of patient who attended had a recommendation for anticoagulant therapy, and 98% of patients stated they had sufficient time to discuss their diagnosis with the specialist healthcare professionals and found the educational sessions beneficial. 100% of the patients who attended stated they would recommend this type clinic to other patients.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm 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 evidence we saw confirmed that the GPs had oversight and a good understanding of best treatment for each patient's needs.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. The gold standard framework guidance was implemented by the practice. We were told there were rarely any issues out of hours as the GPs had been effective in planning and implementing care which supported patients.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attending mandatory courses such as annual basic life support. If there were gaps in training, particularly e learning, this was highlighted and planned for individual staff. We noted a good skill mix among the GPs with interest in women's health, research and orthopaedics. 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).

The practice had an established pattern of meetings to ensure staff understood the demands of the service. There was a weekly managers meeting which allowed staff to be informed and plan for any events in the forthcoming week. The IT manager demonstrated the rota system in place for all the different staffing groups and sites which ensured that the correct staff in sufficient numbers 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.

The practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, insulin initiation, administration of vaccines, cervical cytology and family planning. We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisals identified learning needs from this action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the community nursing team.

There was multidisciplinary team working for patients identified as at risk through age, social circumstances and multiple healthcare needs. Regular meetings with other professionals such as the community matron, community nursing teams, health visitors, palliative care team took

Good

Are services effective?

(for example, treatment is effective)

place. Staff felt this system worked well and there was a team approach to supporting their patients. We were told that the staff were committed to working collaboratively through the federation, so patients who had complex needs were supported to receive coordinated care. For example, the practice referred patients to the Axbridge and Wedmore Community Health Fund in order to access suitable equipment to support patients to stay at home such as pressure relieving mattresses.

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. The practice also used the Choose and Book system for secondary appointments, patient to patient electronic transfer of medical records and summary care records. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also had an internal system for shared documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

Information was shared with other health care professionals in an appropriate way, for example, we heard from community teams that they were able to link into the practice patient electronic records to add information. The community teams also attended meetings at the practice to share information as well as undertake joint visits with practice staff to patients. Health care professionals also had a telephone direct line to contact the practice.

Consent to care and treatment

We found that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling it. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented it in their practice. We were told that patients were supported to make their own decisions and documented this in the medical notes. Patients with a learning disability and those with a diagnosis of dementia were supported to make decisions through the use of care plans, which they were involved with. Care plans were reviewed regularly or more frequently if changes in clinical circumstances dictated it. The practice had a policy, procedure and information in regard to best interests' decision making processes for those people who lack capacity. The practice confirmed that the GPs involved patients and families in 'Do Not Attempt Resuscitation' decisions. We also read this information was recorded on the care plans of vulnerable patients.

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had 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 including a patient's verbal consent which was recorded in the electronic patient notes and written consent for minor surgical procedures.

Health promotion and prevention

The practice had met with the local authority and the Clinical Commissioning Group in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness.

The practice did not offer NHS Health Checks to any patients or smoking cessation as these services were commissioned via the Clinical Commissioning Group from an external contractor. The practice provided information and signposted patients to services which helped maintain or improve their mental, physical health and wellbeing.

We saw patients could be referred to services such as weight management and physical activity sessions.

The practice participated in the national screening programmes such as those for cervical cancer, and bowel cancer. The practice offered a full range of immunisations for children, travel vaccines and flu vaccines. We were told that flu vaccination clinics had been held at weekends to encourage children and families to receive the vaccination. The lead practice nurse was not aware of any processes to follow up patients who had not attended for routine vaccinations.

Good

Are services effective?

(for example, treatment is effective)

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the latest national patient survey information for 2014. The evidence from this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national patient survey showed 93% of patients felt that their overall experience was good or very good and 98% had confidence and trust in the last nurse they saw or spoke to.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 14 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with two patients who had involvement with the patient participation group. They were satisfied with the care provided by the practice. Patients stated they felt GPs took an interest in them as a person and overall impression was one of being caring about them as patients. We were given many examples of the GPs taking time to ensure patients received the care they needed such as making contact with patients outside of normal working hours and contacting secondary medical services to ensure referrals were received. All the patients we spoke with said they would recommend the practice, this was apparent from the national patient survey which reported 91% of patients would recommend the practice.

Patients also spoke highly of the relationships between them and the staff at the practice. We heard staff recognised and respected patients' needs taking personal and social needs into account. For example, the practice worked in partnership with numerous organisations within the area which supported patients with different needs such as the local dementia services and funding a dementia café, and the psychological support service whose project workers are based at the practice for easier access for patients.

Staff and patients told us that all consultations and treatments were carried out in the privacy of a consulting room. Privacy curtains were provided in consulting rooms and treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. In the treatment rooms the nursing staff ran clinics, curtains were provided so patients' privacy was maintained as best as possible when treatment was being carried out. We noted that consultation and treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice receptionists all responded to incoming calls; however glass partitioning separated the reception area from the waiting room which kept patient information private. There was also an area where patients could be taken to talk to the receptionists in private.

There was a clearly visible notice in the patient reception area stating the practice's zero tolerance for abusive behaviour.

Care planning and involvement in decisions about care 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, data from the national patient survey showed 99% of respondents had confidence and trust in the last GP they saw or spoke to, and 91% felt the nurse was good at explaining treatment and results which was above average when compared to other practices in the Somerset Clinical Commissioning Group area.

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

Staff told us that telephone translation services were available for patients who did not have English as a first language. We saw the website had a facility for translation of information.

Good

Are services caring?

We found the practice had used risk stratification tools to identify the required 2% of the patient population had their own care plan. This was linked to the 'Avoidance of unplanned Admissions' enhanced service. We were told that the GPs acted as the care coordinator for a number of patients, and the plans were reviewed following an admission or change in need. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions. Older patients, over 75, had their own named GP.

Patient/carer support to cope emotionally with care and treatment

The 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, 92% said the last nurse they saw or spoke with was good at treating them with care and concern. The patients we spoke with on the day of our inspection and the comment cards we received were also consistent with this patient information. For example, these highlighted that staff responded compassionately towards carers and family members when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen 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. We were told how access to appointments was flexible to patients who were carers, or had difficulty attending the practice because of their caring duties. We were told how the GPs were flexible when providing home visits to reduce the difficulties carers of patients had attending the practice. An example of this being home visits to patients and their carer for influenza immunisations.

Two members of staff acted as a carer's champion for the practice. This meant that all carers were identified and sent relevant information about the monthly coffee mornings run at the practice. Staff (clinical and non-clinical) joined in these events and could signpost patients whenever they become aware someone was a carer to benefits advice, introduction to voluntary agencies and social services, as well as general support. The practice had also produced a specific carers' pack of information to be given to new carers.

The practice had set up an independent charitable 'Health Fund' which was used in a variety of ways to support patients registered at the practice. For example, money from the fund was used for training for carers of people with dementia from the Alzheimer's Society. The trustees for the fund were not employees of the practice which maintained their independence. The practice staff could refer patients in need to the fund for specific requirements such as items of equipment and the fund also purchased equipment for the practice.

Staff told us that if families had 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 on how to find a support service.

The practice was part of the North Sedgemoor Federation which funded the Somerset Village Agent project; this was initiated in 2014 and was funded until 2016. The project used paid, part time, highly trained individuals living in the parish 'clusters' they supported. They helped to bridge the gap between socially isolated, excluded, vulnerable and lonely individuals, and the statutory and/or voluntary organisations which offered specific solutions to identified needs.

The practice also sponsored local events such as the non-alcoholic beverages stand at the Wedmore community beer festival.

The patients and staff we spoke with on the day of our inspection and the comment cards we received gave examples of how the practice was caring towards its patients. One example outlined how the staff understood their role as patient advocates. For example, there was an incident when a hospital left a message on a patient's answerphone. The patient was hard of hearing and went into the surgery concerned because they could not understand the message. The receptionist contacted the hospital for them to find out what the message was about and ensured the patient understood what was being communicated. The practice also facilitated patients to access the volunteer driver scheme to enable them to attend appointments.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to 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. The NHS England Area Team and Somerset Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. One partner acted as the vice chairperson of the local CCG.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. There was also triage service so that urgent requests were assessed and requests were prioritised according to need. The practice had provided a responsive service by holding clinics, such as the diabetes clinic, on a regular day each week for patients who found it difficult to attend variable appointment times.

There was a computerised system for obtaining repeat prescriptions and patients used both the electronic request service, posted or placed their request in a drop box in reception or outside the building. Patients told us these systems worked well for them.

The practice had identified that they could support patients by reducing the need to attend hospital for minor operations. Two GPs with specialist interest provided minor operations in the practice and joint injections as required.

We found the practice had reorganised the childhood immunisation clinics to respond to the poor attendance at clinics. The clinic at Wedmore was very poorly attended with lots of 'Did Not Attend', so they decided to stop that clinic and the children would all come to Axbridge on 4th Monday of each month, unless transport was an issue, in which case they saw the child in normal clinic times. Over the last six months they worked with Public health England who send out invitations to the pre-school children and the 12-13 month vaccination children, to phone and book appointments in the nurse's routine clinics, which had been very successful.

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice had their equality and diversity statement on their intranet. The practice provided equality and diversity training for all staff. We also saw that the information on the website could be translated and that the self-booking in system was available in alternate languages.

The premises and services at Axbridge had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The services for patients were on the ground and first floor; however there was lift access to the first floor. The practice at Wedmore did not have easy access for patients who were wheelchair users, or mothers with pushchairs. The toilet at Wedmore was poorly equipped for patients with restricted mobility.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in a residential or nursing home. The GPs took responsibility to carry out reviews of patients with long term conditions who could not attend the practice. We also found that the practice was involved in co-commissioning of specialist services with other practices, such as the Village Agent.

The practice actively supported patients who had been on long-term sick leave to return to work by referring them to other services such as physiotherapists, counselling services and by providing 'fit notes' for a phased or adapted return to work.

Access to the service

The Axbridge site was open Monday – Friday, 8am - 6.30pm and Wedmore Surgery Monday & Friday 8am - 6.30pm, Tuesday, Wednesday and Thursday 8am-1.00pm. Extended hours with pre-bookable appointments were available on Wednesday and Thursday 6.30pm - 8pm at Axbridge site on alternate weeks; and at the Wedmore Surgery on Wednesday and Thursday 7am - 8am once a month, and Saturday 8am - 9.30am on alternate weeks. The practice also offered a GP telephone triage and consultation service. This had been reviewed and found to be very effective.

Good

Are services responsive to people's needs?

(for example, to feedback?)

The practice did not provide out of hour's services to its patients, this was provided by South Western Ambulance Service NHS Foundation Trust information on the out-of-hours service was provided to patients. Appointments were available outside of school hours for children and young people. Comprehensive information was available to patients about appointments, on the practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

Patients told us they were aware that appointment times were not limited to ten minutes but lasted for however long was needed. This system was valued by patients although it meant that they may have had to wait beyond the time they expected. Patients were made also aware when they arrived for appointments if appointment times were late, and that if a child or baby arrived and needed to be seen urgently, then they would be seen by the next available GP. The patients were aware that they could request to see a specific GP otherwise we were told they were happy to see any of the GPs at the practice. For pre-booked appointments patients could choose which GP they saw so there was continuity in their care. The practice also had an online booking system for planned appointments.

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. This also included appointments with a named GP or nurse. The patient record system had an alert to indicate patients who required longer appointments. Home visits were made to local care homes by GPs as part of the daily home visit allocation

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. The practice manager was the designated responsible person who handled all complaints in the practice. There was a method to identify common areas of complaints. Each complaint or comment was also reviewed. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team.

We looked at all the complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The practice took account of complaints and comments to improve the service, for example, complaints were discussed by the team so staff could contribute and learn.

We saw that information was available to help patients understand the complaints system. Information was on display in the patient areas and included on the practice website. There were leaflets provided for patients to take away if they wished to with details of how the complaints process worked and how they could complain outside of the practice if they felt their complaints were not handled appropriately. None of the patients we spoke with had ever needed to make a complaint about the practice but told us they felt the practice would listen and respond to their concerns.

The practice also recorded compliments received from patients and ensured these were shared amongst the staff in recognition of good practice.

Are services well-led?

Requires improvement

(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 vision to deliver high quality care and promote good outcomes for patients as identified in their statement of purpose. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. This was corroborated by the patients we spoke with. The comprehensive practice booklet stated 'To promote better health for all we believe in the 'team approach'. The practice also participated and engaged with colleagues as part of the North Sedgemoor Federation for commissioning of services. We found examples of involvement in innovative schemes such as the acute community eye care service for Somerset (ACES) which is a free service available to all patients registered with the practice and was designed for the assessment and treatment of recently occurring medical eye conditions.

Governance arrangements

Staff were able to demonstrate their understanding and commitment to providing high quality patient centred care. The practice had a number of policies and procedures in place to govern activity and these were available on a shared drive which staff could access from any computer in the practice. We looked at a number of these policies and procedures and found that they had been reviewed. GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work.

Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. The practice also had a policy to follow for patients who made freedom of information requests. Staff we spoke to confirmed they understood these topics and would be able to offer support to patients.

We heard that decisions about the practice were taken by the partners who had a shared leadership approach. There was an agreed strategy in place with named partners in lead roles, for example, one GP partner led on research and another worked as the chairman and link to the Somerset Clinical Commissioning Group. We saw that buddy arrangements between doctors were clearly documented and staff told us this worked very well in practice and provided a safety network for patients.

We spoke with 10 members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns. We found that the responsibility for improving outcomes for patients was shared by all staff.

The practice held weekly governance meetings to discuss serious and significant events, complaints, patient feedback and other information relating to the quality of the service. We saw meeting minutes and reports that demonstrated the practice routinely reviewed data and information to improve quality of service and outcomes for patients. There was evidence that the practice took the welfare of its staff seriously for example, performance was reviewed in order to enable staff to develop and improve and there were social events regularly throughout the year for all staff to enjoy.

We discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services. For example, the avoiding unplanned admissions enhanced service meant the practice had care plans in place for at risk patients. We found the practice had systems in place for monitoring this area of practice. However the practice did not have easily accessed information about other areas of performance. Specifically we asked about annual reviews for patients with a learning disability and were told that of 10 patients registered, records indicated that only one had attended for their health check. The practice could not provide any information why the level of performance was at 10%, although we were given verbal assurance patients had been reviewed.We also asked the lead nurse how they recorded childhood immunisations and particularly patients who failed to attend for routine immunisations. The lead nurse was unable to provide full information about this process, for example, if any follow up action was taken.

The practice periodically looked at other indicators such as survey results, other forms of patient feedback, sudden deaths, diagnosis of new cancers and staff appraisals to provide an in depth review of service provision and shape their ongoing business plan.

Leadership, openness and transparency

The practice employed a practice manager to enable the business and administration of the service. The practice manager was new in post but understood their

Are services well-led?

Requires improvement

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

responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of policies, for example the recruitment policy and induction programmes which were in place to support staff. The practice manager acknowledged that they had not undertaken a complete review of the practice but had already instigated change such as ensuring there was a weekly, rather than monthly, partners meeting to plan and take all the decisions related to the practice. We looked at the minutes from past meetings and saw how the meetings were used as an information sharing and decision making forum.

There was an established management structure, we spoke with a number of staff, both clinical and non-clinical, and they were all clear about their own roles and responsibilities. They were able to tell us what was expected of them in their role and how they kept up to date. Staff told us they felt supported by the practice manager and referred decisions and queries to them. We heard from staff at all levels that team meetings were held regularly and that the practice held a yearly meeting which representatives from all staff groups attended. We saw minutes from meetings attended by the administrative and reception staff but not for the nursing team.

Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. Staff told us they felt confident about raising any issues and felt that if incidents did occur these would be investigated and dealt with in a proportionate manner.

The practice was proactive in planning for future needs; GPs and nurses were being provided the opportunities and access to additional training to develop new services and enhance their skills.

The practice had invited a number of key stakeholders to speak with us during the inspection. All spoke highly of the practice and how well the practice worked jointly with their organisation.

The senior GP partner held lead responsibility within the practice as the Caldicott Guardian and was clear about their role. A Caldicott Guardian is a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian; this was mandated for the NHS by Health Service Circular: HSC 1999/012. The practice had protocols in place for confidentiality, data protection and information sharing.

Seeking and acting on feedback from patients, public and staff

The practice demonstrated a commitment to seeking and listening to patient views. They showed us a range of evidence, such as patient feedback, compliments and complaints they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement. For example, as a result of comments generated from the survey, the Health Fund committee agreed to support plans by the Patient Participation Group in conjunction with the practice to build a directory of services which will be available for patients to access online, and in particular at the regular coffee mornings held in the Jack Todd Suite, at the practice.

The practice also explained how they looked at ways to improve the service and following comments made via the Friends and Family Test had made changes to the way appointments are scheduled and in particular around bank holidays.

The practice also had a virtual PPG of approximately 312 members who were consulted about surveys and changes within the practice such as the decision to stop telephone prescription requests.

The practice had gathered feedback from staff through staff away days and generally through staff meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. One member of staff told us that they had asked for specific training and this had happened. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice. There were high levels of staff satisfaction. Staff told us they were proud to work for the practice.

Management lead through learning and improvement

Are services well-led?

Requires improvement

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

There was a strong focus on improvement and learning shared by all staff. The staff we spoke with demonstrated an understanding of their area of responsibility and each took an active role in ensuring a high level of service was provided on a daily basis. The GPs and nurses we spoke with told us how they conducted routine condition and medicines reviews. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Somerset Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Learning also came from clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date. Significant events were a standing item on the practice meeting agenda and were attended by the GPs, lead nurse and the practice manager. Recent significant events were discussed and we were told by GPs they also reviewed actions from past significant events and complaints. There was evidence the practice had learned from these events and that the findings were shared.

We found the practice had a positive culture for training and held monthly afternoon sessions for staff to attend. However, through talking with staff, not all information given at training sessions had been absorbed or put into practice. For example, the responses given by staff to questions about safeguarding and emergency protocols did not demonstrate a cohesive understanding by staff of the correct protocols to follow.

The practice was a GP training practice with two partners taking the lead for GP training. The ethos of the practice was that GPs in training brought new ideas and ways of working to the practice, and were able to challenge established practice. It also provided practical experience for medical and nursing students. We also received comments from a GP who had completed their training at the practice which praised the quality of the training and support from the staff team as a whole.

Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. Staff told us that the practice was very supportive of training. Staff told us they had been involved in appraisal.

The surgery took part in research some of which were stage 3 trials (pre-licensing), for example the practice took part in the fast track safety approval of the swine flu vaccine. The majority of the research was observational monitoring of patients. This involvement contributed to the practice remaining up to date with latest developments in clinical care.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **People who use the service were not protected by robust systems which ensured the service was monitored for quality and safety and that any risks had been fully mitigated.**

Regulated activity	Regulation
Diagnostic and screening procedures Family planning services Maternity and midwifery services Surgical procedures Treatment of disease, disorder or injury	Regulation 15 HSCA (RA) Regulations 2014 Premises and equipment **People who use services and others were not protected against the risks associated with unsafe or unclean premises because of inadequate maintenance and poor standards of hygiene. Regulation 15 (1) (a), (e), (2).**