

# Dr Ian Kelham

## Quality Report

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

## Ratings

Overall rating for this service	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

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## Overall summary

### Letter from the Chief Inspector of General Practice

#### OUTSTANDING

We carried out an announced comprehensive inspection at Dr Ian Kelham (Porlock Medical Centre) on May 7 2015. Overall the practice is rated as outstanding.

Specifically, we found the practice to be outstanding for providing responsive, caring and effective services. It was also outstanding for providing services for older people and people with long term conditions. It was good for providing safe and well led 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.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice. For example a project with Age UK; tele-dermatology with hospital consultants and practice visits by the endocrinologist.
- 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 that they meet 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).

# Summary of findings

- 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
- 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 to patients by specialist hospital consultants.

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 writing a healthy lifestyle article in the local magazine; providing an annual flu vaccination clinic which included invitation to local organisations to attend and an annual men's health evening to promote better health. 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?

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.

Good



### Are services effective?

The practice is rated as outstanding for providing effective services. Our findings at inspection showed that 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. Data showed that 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.

Outstanding



### Are services caring?

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 to achieving this. We found many positive examples to demonstrate how patient's choices and preferences were valued and acted on. Views of external stakeholders were very positive and aligned with our findings.

Outstanding



### Are services responsive to people's needs?

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 on suggestions for improvements and changed the way it delivered services in response to feedback from the patient

Outstanding



# 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?

The practice is rated as outstanding for being well-led. The practice had a clear vision with quality and safety as its top priority. The strategy to deliver this vision had been produced with stakeholders and was regularly reviewed and discussed with staff. High standards were promoted and owned by all practice staff and teams worked together across all roles. Governance and performance management arrangements had been proactively reviewed and took account of current models of best practice. The practice carried out proactive succession planning. There was a high level of constructive engagement with staff and a high level of staff satisfaction. The practice gathered feedback from patients using new technology, and it had a very active patient participation group (PPG).

**Outstanding**



# Summary of findings

## The six population groups and what we found

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

### Older people

The practice is rated as outstanding for the care of older people. The practice had over twice the national average of over 65s, and four times the national average for the over 85s. 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 dementia and 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.

Outstanding



### People with long term conditions

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.

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

Outstanding



# Summary of findings

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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**

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 that 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.

**Good**



## **Working age people (including those recently retired and students)**

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

**Good**



# 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

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 had carried out annual health checks in conjunction with a local GP who had clinical expertise in learning disabilities and 100% of these patients had received a follow-up. It offered longer appointments for people with a learning disability.

The practice regularly worked with multi-disciplinary teams in the case management of vulnerable people. It 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.

Good



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

The practice is rated as good for the care of people experiencing poor mental health (including people living with dementia). People experiencing poor mental health had received an annual physical health check which included preventative health screening for heart disease. 79% had an agreed care plan. 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.

Good



# Summary of findings

## What people who use the service say

We spoke with four patients who visited the practice every week, members of the patient participation group (PPG) and the Friends of Porlock Surgery (a registered charity raising funds for the practice to help improve the comfort of patients and secure additional services and equipment) during our inspection. We reviewed 49 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. Almost all the comments stated that as a patient they felt looked after and fortunate.

The practice had an active PPG with 12 members of varied ages and included representation from patients with long term conditions and those from the rural farming community. The PPG has been established for fifteen years and included members of the Friends of Porlock Surgery charity. The chair is active in local health forums and the PPG had set up a local federation for PPG chairs. The PPG members we spoke with told us the GP's 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 were receptive, interested in improving patient experience and proactive. The PPG were also encouraged to attend practice meetings. We

were told about the PPG survey (2014) and saw the 2013 annual PPG report. We could see evidence during our inspection that the practice had addressed a concern from patients with regards to waiting times. The practice had allowed catch up slots as well as slots for telephone calls and urgent appointments to reduce patient waiting times. The practice had also increased blood test appointments with the health care assistant so that the GP had more availability. The PPG told us the quality of medical service was outstanding and patients were happy with the efficient service provided.

We looked at the NHS Choices website to look at comments made by patients about the practice. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We saw that there was one review since February 2014 which was positive.

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. 100% of patients describe 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. 98-100% of patients would recommend the service they had received to their friends and family.

## Outstanding practice

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 to patients by specialist hospital consultants.

## Summary of findings

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 writing a healthy

lifestyle article in the local magazine; providing an annual flu vaccination clinic which included invitation to local organisations to attend and an annual men's health evening to promote better health. All these were not limited to the practice population. The practice had undertaken a project with Age UK to provide support to isolated patients.

# Dr Ian Kelham

## 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 two CQC inspectors.

### Background to Dr Ian Kelham

Porlock Medical Centre provides primary medical services to approximately 1,900 patients living in Porlock 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 England's national general practice profile shows the practice has a significantly lower population of patients aged between 0 and 39 years old with the lowest population number of under eighteens than the rest of Somerset Clinical Commissioning Group (CCG) area. A higher than England average group of patients aged over 50 is reflected by Porlock village having the longest living population in Europe with over 40% of pensionable age (Office National statistics 2010). The practice population has higher levels of deprivation (21.9%) compared with the local CCG average of 16.8% and England average of 21.5%.

The surgery was purpose built and is owned by the GP's. The building is set over two floors with patient services provided on the ground floor. It has an access ramp to the entrance of the building and a car park with disabled parking. The practice has a purpose built indoor and outdoor children's play area. There is a scented garden which was designed by patients and planted by the learning disability team patients.

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 and administration staff. All three GP's, some of the nursing team and the practice manager work across this practice and Dunster surgery. Dr Kelham began management of Dunster Surgery in 2009. 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 who 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 7 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, 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 provide 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 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)

# 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 in December 2014 a staff member had arrived at the practice and found the vaccine fridge alarm was sounding as the fridge temperature was above the required level for vaccine storage. We saw evidence that the correct procedures were followed to ensure the vaccines were safe and effective to use and this included contacting external agencies.

We saw evidence that the practice prioritised risks that were identified by external agencies. For example, the company that delivered liquid nitrogen raised concerns around the cobbled pavement which could potentially result in the delivery tipping onto the ground. The practice carried out a risk assessment and followed their procedures which resulted in the pavement format being changed. We saw that 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 seven significant events that had occurred during the last year and saw this system was followed appropriately. Significant events was 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 that the practice had learned from these and that the findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at the meetings and they felt encouraged to do so.

Staff used incident forms and sent completed forms to the practice manager. We saw the system used to manage and monitor incidents. We tracked all seven incidents and saw records were completed in a comprehensive and timely manner. We saw evidence of action taken as a result and that the learning had been shared. For example a patient had convinced a local pharmacy that the medicine prescribed to thin the blood (anticoagulant) should be a higher dose. This was identified at the practice; a serious incident process was followed and the pharmacist was included in the findings and lessons to be learnt. We saw that 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 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 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 that all staff had received relevant role specific training on safeguarding. We asked members of medical, nursing and administrative staff about their most recent training. Staff knew how to recognise signs of abuse in older people, vulnerable adults and children. They were also aware of their responsibilities and knew how to share information, properly record documentation of safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details 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

## Are services safe?

necessary competency and training to enable them to fulfil these roles. All staff we spoke with were aware who these leads were and who to speak with in the practice if they had a safeguarding concern.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example we saw that four children had an alert for potential risk of harm. All children and young people who attended accident and emergency were monitored. The nurses told us about an example of a child who was attending the minor injuries unit regularly due to his asthma. We saw that an alert and appropriate codes for poor medication compliance and regular hospital attendance had been placed on the medical records.

We saw that 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. For example we saw an alert for a vulnerable person who had not attended for monitoring of their blood levels for medicines for mental illness. We saw that the practice had a system to make contact with the patient.

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 when a child had sustained a second fracture. We saw that the GP had raised concerns and had discussions with the school to decide on the most appropriate pathway.

We saw evidence of good liaison with partner agencies. For example a vulnerable adult with a learning disability had come to the attention of the Police, the GP had engaged with the Police and worked jointly with them to educate and support the patient to prevent criminal prosecutions. We saw another example of a patient who had disclosed domestic abuse to reception staff. The staff had appropriately referred to the GP who had supported the patient and arranged a place of safety in a refuge. The GPs told us about their engagement with multi agency

safeguarding 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 medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a policy for ensured that medicines were stored at the required temperatures, which described the action to take in the event of a potential failure. Records showed room temperature and fridge temperature checks were carried out which ensured medication was stored at the appropriate temperature. We saw that a recent problem with the temperature regulation of the refrigerator had resulted in the practice purchasing advanced equipment to monitor temperatures when the practice was closed.

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. They carried out regular audits of the prescribing of controlled drugs. Staff were aware of how to raise concerns around controlled drugs with the controlled drugs accountable officer in their area.

The practice kept emergency controlled drugs for heart problems and one opiate medicine vial in a grab bag in reception. The GPs took this bag when they went on

## Are services safe?

emergency call outs. We spoke to the staff about the requirement to keep medicines secure and in a tamper proof container. Staff immediately moved and secured the medicines appropriately. After our inspection we received an appropriate risk assessment which included the removal of medicines from the grab bag and confirmation that they were no longer stored in reception.

Other medicines were stored in an unlocked cupboard. We saw that the treatment room was locked when not in use. We spoke to staff about medicines security. Following our inspection we received confirmation that locks had been placed on the cupboard.

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.

The practice nurses carried out cryosurgery, using liquid nitrogen, for a variety of skin lesions, for example the removal of warts. We saw that the appropriate precautions were in place for storage and use, for example, access to appropriate protective equipment.

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.

We saw records of practice meetings that noted the actions taken in response to a review of prescribing data and action taken with regards to prescription management.

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. Appropriate action was taken based on the results.

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. The health care assistant administered vaccines using Patient Specific Directions (PSDs) that had been produced by the prescriber. We saw sets of PGDs that had been updated in 2014. We saw evidence that nurses and

the health care assistant had received appropriate training and been assessed as competent to administer the medicines referred to in a PGD or in accordance with a PSD from the prescriber.

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.

### 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 bi-weekly and annual cleaning specification for the contract cleaners to undertake. 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 on 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 that 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 that 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.

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

## Are services safe?

assessment that confirmed the practice had not identified any potential risk due to there being no significant hazards. The water system in the practice had been installed with legionella risk reduction in mind. However 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 that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records that confirmed this. All portable electrical equipment was routinely tested and displayed stickers indicating the last testing date 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. We saw that two items of equipment in one doctors bag were overdue a calibration check. The practice immediately removed the equipment and we saw evidence that the equipment was calibrated two weeks after our inspection.

There were records for servicing to the boiler and lift.

### 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 that appropriate recruitment checks had been undertaken prior to employment. For example, proof of identification, references, qualifications, registration with the appropriate professional body and the appropriate checks through the Disclosure and Barring Service (These checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable).

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 health care assistant was also trained to assist reception at busy times.

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.

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 four examples of risk, for example, the risk of falls to patients in the car park during times of ice or snow and the risk for two pregnant members of staff and the mitigating actions that had been put in place. The meeting minutes we reviewed showed risks were discussed at practice meetings.

We saw that staff were able to identify and respond to changing risks to patients including deteriorating health and well-being or medical emergencies. For example, there 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 medication for mental ill-health. For example patients receiving medication that required monitoring through blood testing would have their medical records checked to ensure attendance.

### Arrangements to deal with emergencies and major incidents

## Are services safe?

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

Emergency medicines were easily accessible to staff in a clinical area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. However we saw that one dose of an opiate used for pain relief was stored in a secure box within a grab bag for emergency visits in an area where there was potential for patients to have access. We spoke to the practice and the medicine was removed immediately. The practice has since advised us of the updated policy. 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.

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. We saw the contingency plan for the closure of the main road for 12 weeks, where the Dunster practice was located. Although this practice served a different population group, staff would have to take a 25 mile detour in order to commute between practices for clinics. We saw that an effective plan had been put into place and a lessons learnt analysis completed afterwards.

The practice had carried out a fire risk assessment in 2015 that included actions required to maintain fire safety. We saw evidence that there was a process in place to check fire equipment and carry out fire alarm tests. Training records showed that fire training had not been recorded. We spoke with staff who were able to tell us about fire training they had undertaken and what they should do in the event of a fire.



# 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 that guidance from local commissioners was readily accessible in all the clinical and consulting rooms.

We discussed with the practice manager, GPs and nurses how NICE guidance was received into the practice. They told us this was either downloaded from the website and disseminated to staff or the local patient and medicines management pharmacist provided regular summaries. We saw that GPs regularly used NICE clinical knowledge summaries and shared information between them. 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 with long term conditions were reviewed six monthly to ensure their treatment remained effective. For example, the practice had 131 patients with diabetes and 100% had received a six monthly health check and 91% had attended regular eye screening programmes; 68 patients at the practice had chronic obstructive pulmonary disease and 94% had received a six monthly health check; All patients with more than one long term condition had attended for six monthly medicine reviews.

The GPs told us they lead in specialist clinical areas such as minor surgery, diabetes, heart disease and asthma and the practice nurses supported this work, which allowed the practice to focus on specific conditions. Clinical staff we spoke with were 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, for the management of respiratory disorders.

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

### Management, monitoring and improving outcomes for people

Information about people's care and treatment, and their outcomes, was routinely collected and monitored and this information 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, 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 had a system in place for completing clinical audit cycles. The practice showed us 13 clinical audits that had been completed 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, following a change in law around medicine usage and driving an audit was carried out with regards to prescriptions that had PRN (take as needed) written on them.

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 a change to preventative treatment (in line with blood results rather than gout attacks). A repeat audit showed an improvement when compared to the results of the initial audit. Other examples included audits for antipsychotic medications; dementia screening and coeliac disease which confirmed that 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 that five audits were



# Are services effective?

## (for example, treatment is effective)

comparison audits between Porlock and Dunster 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 that 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 and utilised a risk stratification tool to guide their intention to review medicines. We saw that 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 99% 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 that all clinical staff should undertake at least one audit a year.

The practice's prescribing rates were also similar or better to national figures. There was a protocol for repeat prescribing which followed national guidance. This required staff to regularly check patients receiving repeat prescriptions had been reviewed by the GP. They also checked all routine health checks were completed for long-term conditions such as diabetes and that the latest prescribing guidance was being used. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines. 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. For example diabetes where 100% of patients had received a six monthly and annual review in the last year.

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 pre-diabetes 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 that were comparable to other services in the area.

### Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw that all staff were up to date with 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; integrated health and social care implementation and the school of primary care. This told us that 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 had been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

All staff undertook annual appraisals that identified learning needs from which action plans were documented. Our interviews with staff confirmed that the practice was



# Are services effective?

## (for example, treatment is effective)

proactive in providing training and funding for relevant courses, for example a nurse had received training to provide minor surgery and a receptionist had undertaken a medical terminology course. 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 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, on administration of vaccines, cervical cytology and minor surgery. Those with extended roles in long term conditions including diabetes, asthma and chronic lung diseases were also able to demonstrate that they had appropriate training to fulfil these roles.

### Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and manage those of patients with complex needs. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, Out Of Hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising 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 14.4% compared to the national average of 13.6%. The practice was able to show us data that compared the practice with Dunster surgery and local practices. This data showed that emergency admission rates were low compared to other practices. The practice had a process in place to follow up patients discharged from hospital. We saw evidence that a patient

discharged after a stroke was telephoned proactively by the GP and an offer of a home visit that day was made. We saw that the practice protocol for actioning hospital communications was working well in this respect.

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 that the GP's respected their views and assessments and acted on 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.

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).

Electronic systems were also in place for making referrals, through the Choose and Book system. (Choose and Book is a national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital). Staff reported that this system was easy to use.

The practice had systems to provide staff with the information they needed. Staff used an electronic patient



# Are services effective?

## (for example, treatment is effective)

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. We saw evidence that 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 that staff were aware of the Mental Capacity Act 2005, the Children Acts 1989 and 2004 and their duties in fulfilling them. All the clinical staff we spoke with understood the key parts of the legislation and were able to describe how they implemented them. 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. The practice showed us that 79% of patients with mental ill-health had care plans which had been reviewed in the last year. When interviewed, staff gave examples of how a patient's best interests were taken into account if a patient did not have capacity to make a decision. Nurses and GPs 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 patient's verbal consent was documented in the electronic patient notes with a record of the discussion about the relevant risks, benefits and possible complications of the procedure. In addition, the practice obtained written consent for significant minor procedures and all staff were clear about when to obtain written consent.

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.

One GP had been part of a local initiative to improve integration between GPs and Independent Mental Capacity Advocates.

### 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 health check to all new patients registering with the practice. The GP was informed of all health concerns detected and these were followed up in a timely way. We noted a culture among the GPs 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 that 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 98% of patients over the age of 16. In 2014 169 patients attended nurse-led smoking cessation clinics. There was evidence these were having some success as the practice had a higher quit rate of smoking 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.

The practice's performance for the cervical screening programme was 87%, which was above 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



# Are services effective?

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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. 82% of patients had attended breast cancer screening which is above the South West Region average of 79%.

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 the patients over 65 years was 76%; childhood immunisation rates for the vaccinations given to under twos was 100% and five year olds 100%. The results for both examples were above the national average.

One GP wrote a regular column in the village magazine on health advice and education for the local community. For example articles on smoking and sexual health. The practice held a men's health event in 2014, arranged by the patient participation group which provided local men with advice on health and wellbeing.

The practice provided exercise on prescription and we saw evidence that 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.



# 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 national patient survey (March 2015); a survey of 107 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 that 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 on consultations with doctors and nurses. For example:

- 98% said the GP was good at listening to them compared to the CCG average of 92% and national average of 89%.
- 98% said the GP gave them enough time compared to the CCG average of 90% and national average of 87%.
- 99% said they had confidence and trust in the last GP they saw compared to the CCG average of 97% and national average of 95%.
- 100% said the nurse gave them enough time compared to the CCG average of 95% and national average of 92%.
- 99% 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 49 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. They said staff treated them with dignity and respect. We also spoke with four patients on the day of our inspection. All 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 that all consultations and treatments were carried out in the privacy of a consulting room. Curtains were provided in consulting rooms and

treatment rooms so that patients' privacy and dignity was maintained during examinations, investigations and treatments. We noted that consultation / treatment room doors were closed during consultations and that conversations taking place in these rooms could not be overheard.

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk and was shielded by glass partitions which helped keep patient information private. We saw that patients could not overhear potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained. Additionally, 100% of respondents described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.

Staff told us that 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 saw that reception had a surveillance camera. We were told that this was installed after a member of staff was threatened. The practice had undertaken a risk assessment which showed that there were times when risk to staff was increased, for example at 7.30am when only one member of staff was in the building. Patients had not made any comments or complaints about the camera.

Staff told us that the practice was accessible to anyone. We saw evidence that a mother and daughter with learning disabilities, who were not registered with the practice, had been provided with medical support and care.

Staff told us about how they had carried out a patient's wish to receive end of life care at home. The patient had died in her garden where she had wanted to with the GP present. As a result the GP received a generous donation yearly which they used to provide enhanced care to the local



## Are services caring?

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 registered at the practice. We saw that 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 was able to use his surgical expertise to undertake procedures which were normally undertaken at the county hospital. An example was given of a patient who had developed a fluid collection following cancer surgery which the GP was able to treat with drainage to provide comfort. This was done so that patients with cancer who were also nearing the end of their life did not have a long, uncomfortable journey to hospital

We observed one GP calling a young child into the consultation room. We saw that the GP spoke to the child in an encouraging way, using appropriate language, voice pitch and body language. We saw that the child reacted positively.

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 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:

- 93% 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%.
- 97% 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%.
- 98% 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%.

- 96% 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 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 translation services were available for patients who did not have English as a first language. We saw notices in the reception areas informing patients this service was available.

The practice had recently started a pilot project with Age UK where volunteers would visit patients with two or more long term conditions 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.

The practice 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%.
- 99% 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%.



## Are services caring?

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

Notices in the patient waiting room and patient website also told 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 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. Dr Kelham provided a direct contact number for patients receiving end of life care so that they could have continuity of care in the evenings and weekends.

One patient told us that they had nothing but praise for the support the practice had given to his wife and to him as a carer. 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. We were told about an example when the group was meeting in the practice and a member of staff identified that a carer was waiting for an appointment with a GP. The member of staff asked the carer's coordinator if they would meet the patient before they left.

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 had good links with 'village agents', people identified as able to visit isolated patients to offer companionship. The practice also 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 that patients' emotional and social needs were seen as important as their physical needs. For example the Age UK project and the role of the home support nurse.



# 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 improved patient access to appointments following feedback from the Patient Participation Group.

The NHS England Area Team and 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. Both partners undertook additional roles within these organisations.

The practice received a yearly practice profile from 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. End of life patients at the practice had a higher than average death rate at home (32%).

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 that 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 on managing traffic accidents and the hospital urology nurse talking about prostate health. The practice run a flu day annually which the PPG and staff describe as a large social event attracting 400 people. The event was inclusive of people in the village who are registered with another GP and included other community organisations such as carers support, the Police and energy firms. (Porlock's high deprivation is reflected by the number of patients in fuel poverty).

We saw other examples of the practice being responsive to patient needs for example, working with the Police to manage a complex person with a learning disability. 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 that this has 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. For example a patient with cancer was able to have an area of fluid collection drained at the practice rather than travel an hour to hospital. We saw that the practice engaged with the specialist end of life care team who supported the additional service provision provided by the practice.



# Are services responsive to people's needs?

(for example, to feedback?)

## Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. For example, longer appointment times were available for patients with chronic diseases. Patients with a learning disability had their annual reviews carried out by a GP from a local practice who was an expert in this area. This did not prevent patients from seeing GPs of choice at the practice. 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 on advocacy services available for patients.

The premises and services had been designed to meet the needs of people with disabilities. The practice was accessible to patients with mobility difficulties as facilities were all on one level. The consulting rooms were also accessible for patients with mobility difficulties and there were access enabled toilets and baby changing facilities. There was a waiting area with plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. An indoor and outdoor play area for children had been created along with a sensory garden.

Staff told us that 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 that 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 that 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.

## Access to the service

The surgery was open from 08:00 to 18:30 Monday to Friday except Wednesday when the practice closed at 13:00. Dunster surgery covered the practice on Wednesday afternoons. Appointments were available from 08:10 to 11:00 Monday to Friday and 16:00 to 17:30 (except Wednesdays). Early morning appointments from 7am were available for three days. Urgent appointments were available daily and any child under five was 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. Physiotherapy, 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 on 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:

- 93% were satisfied with the practice's opening hours compared to the CCG average of 77% and national average of 75%.
- 100% described their experience of making an appointment as good compared to the CCG average of 79% and national average of 73%.
- 90% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 70% and national average of 65%.
- 100% said they could get through easily to the surgery by phone compared to the CCG average of 79% and national average of 73%.



# Are services responsive to people's needs?

(for example, to feedback?)

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed that 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 that 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 complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

We saw that information was available to help patients understand the complaints system. This included online information, leaflets and posters. The practice also provided a comments box in the waiting room. 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 two complaints received in the last 12 months. We identified no themes from the practice complaints log and found the quality of recording and investigation to be satisfactory. We found the responses from the practice to be open and transparent with the appropriate level of apology. One complaint had also been investigated as a significant incident and we saw evidence that all staff had been involved in a discussion during a team meeting which included lessons learned and actions to improve the quality of care as a result of the complaint.

# 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 that 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 and knew what their responsibilities were in relation to these and had been involved in developing them. We looked at minutes of the practice meetings and saw that 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 were shared with Dunster Surgery.

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 that 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 GP and practice manager took an active leadership role for overseeing that 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 Practice Quality 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 that SPQS data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes. Although the practice did not participate in QOF they worked with the National Institute for Health and Care Excellence (NICE) as a test site for new indicators of quality. As part of the process, the practice compiled an annual report and representatives from NICE visited the practice.

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 with diabetic between the two practices and another the prescribing of antipsychotic medication which was done in line with NICE guidance for prescribing this. 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 that the practice leaders proactively engaged with them around

# Are services well-led?

Outstanding



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

practice performance and quality improvement. We saw that the practice received an annual practice profile from Public Health England which they used with the PPG to target priority areas that required improvement.

The practice regularly submitted governance and performance data to the CCG. CCG data was used by the practice to measure their performance with Dunster Surgery 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 emergency lighting and safe installation of sharps boxes. (Sharps boxes are used to safely store clinical waste such as needles and syringes). 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, 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 on 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 in the practice and staff told us that 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 that 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 that 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 of the practice such as a role with the Clinical Commissioning Group and a role with NHS England. Both partners worked with the Local Medical Committee. Staff told us that these roles helped the practice enhance the quality of care and provided a network of contacts for a small rural practice.

The practice is aware that Dr Kelham holds the business memory for the practice having been at the practice since 1996 and was until 2009 a single handed GP 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 and complaints received. It had an active PPG which included representatives from various population groups; for example a member with young children 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. We spoke with three 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. For example, when the practice was considering taking on responsibility for provision of services at Dunster Surgery the PPG were actively involved in discussions and the practice welcomed constructive challenges from the group about the sharing of staff between the two sites. (A PPG is a group of patients registered with a practice who work with the practice to improve services and the quality of care).

# Are services well-led?

Outstanding



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

We also saw evidence that 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 to attend the practice to reduce the impact of a rural community having to travel to appointments. 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 that the practice supported them to maintain their clinical professional development through training and mentoring. We looked at staff files and saw that regular appraisals took place which included a personal development plan. Staff told us that the practice was very supportive of training.

The practice was 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. We were told that there was a culture of learning for all clinical staff for example, we saw evidence that the practice valued GP trainees and had changed their own practice in order to improve quality. For example nurses would circulate changes in guidance or relevant clinical research; blood tests 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.

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, we saw that the practice had been involved in pilot projects for example work with NICE around new QOF measurements; the Age Concern project and the employment of the home support nurse who worked with voluntary agencies. 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 telephone consultation had been requested and reception staff had listed the consultation wrongly which resulted in the GP leaving the practice and not telephoning the patient. We saw that 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.

We were told about an unexpected death from asthma that happened locally. The practice staff had undertaken a lessons learnt session which had resulted in changes to practice; updating of asthma clinic templates and liaison with the British Thoracic Society around inhaler usage (which led to a change nationally with regards to IT systems recording for over usage of inhalers).

We saw that there was a long history of learning from significant events. For example a death of a young person had resulted in the practice setting up a charity (Friends of Porlock Surgery) in order to provide additional equipment to assist in emergency situations.