Abbey Manor Medical Practice

Quality Report

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

Ratings

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

Summary of findings

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Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Abbey Manor Medical Practice on 24 June 2015. Overall the practice is rated as good.

Specifically, we found the practice to be good for providing safe, well-led, effective, caring and responsive services. It was also good for providing services for all the population groups.

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

- Staff understood and fulfilled their responsibilities to raise concerns, and to report incidents and near misses. Information about safety was recorded, monitored, appropriately reviewed and addressed.
- Risks to patients were assessed and well managed.
- Patients' needs were assessed and care was planned and delivered following best practice guidance. Staff had received training appropriate to their roles and any further training needs had been identified and planned.
- Patients said they were treated with compassion, dignity and respect and they were involved in their care and decisions about their treatment.
- Information about services and how to complain was available and easy to understand.
- Patients said they found it easy to make an appointment with a named GP and that there was continuity of care, with urgent appointments available the same day.
- The practice had good facilities and was well equipped to treat patients and meet their needs.
- There was a clear leadership structure and staff felt supported by management. The practice proactively sought feedback from staff and patients, which it acted on.

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

Importantly the provider should;

- Ensure there is an effective monitoring system in place to monitor staff training including information of what is expected of staff to complete on a mandatory basis and how often.

Summary of findings

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

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

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

Are services effective?

Good

The practice is rated as good for providing effective services.

Staff referred to guidance from the National Institute for Health and Care Excellence and used it routinely. Patients' needs were assessed and care was planned and delivered in line with current legislation. This included assessing capacity and promoting good health. Staff had received training appropriate to their roles and any further training needs had been identified and appropriate training planned to meet these needs. However, the system for monitoring training could be improved. There was evidence of appraisals and personal development plans for staff. Staff worked with multidisciplinary teams.

Are services caring?

Good

The practice is rated as good for providing caring services.

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

The practice reviewed the needs of its local population and engaged with the NHS England area team and Somerset Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. Patients said they found it easy to make an appointment with a named GP and there was continuity of care, with urgent appointments available the same day. The practice had good facilities and was well equipped to treat patients and meet

Summary of findings

their needs. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised. Learning from complaints was shared with staff and other stakeholders.

Are services well-led?

Good

The practice is rated as good for being well-led.

The practice had a clear vision and strategy and staff understood the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity and held regular governance meetings. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from patients and acted upon it to improve practice. The patient participation group (PPG) was active. Staff had received inductions, regular performance reviews and attended staff meetings and events.

Summary of findings

The six population groups and what we found

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

Older people

Good

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

The practice offered proactive, personalised care to meet the needs of the older patients in its population and had a range of enhanced services, for example, in facilitating the timely diagnosis and support for patients with dementia. They were responsive to the needs of older patients, and offered home visits and rapid access appointments for those with enhanced needs including those residing in nursing homes.

People with long term conditions

Good

The practice is rated as good for the care of patients with long-term conditions.

Nursing staff had lead roles in chronic disease management and patients at risk of hospital admission were identified as a priority. Longer appointments and home visits were available when needed. All these patients had a named GP and a structured annual review to check that their health and medication needs were being met. For those patients with the most complex needs, the named GP worked with relevant health and care professionals to deliver a multidisciplinary package of care.

A diabetes information evening was held in September 2014 which was attended by GPs, nurses and a small group of patients. Patients were able to share their experiences with others including those who had been diagnosed recently.

Families, children and young people

Good

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

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 relatively high or average for standard childhood immunisations. Patients told us that children and young patients were treated in an age-appropriate way and were recognised as individuals. 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.

Summary of findings

Working age people (including those recently retired and students)

Good

The practice is rated as good for the care of working-age patients (including those recently retired and students).

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

People whose circumstances may make them vulnerable

Good

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

The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability. The practice had 12 patients registered with a learning disability and they had carried out 60% of annual health checks for patients with a learning disability in the last year.

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

People experiencing poor mental health (including people with dementia)

Good

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

We saw 65% of patients experiencing poor mental health had received an annual physical health check in the last year. The practice regularly worked with multi-disciplinary teams in the case management of patients experiencing poor mental health, including those with dementia. They carried out advance care planning for patients with dementia.

The practice had told patients experiencing poor mental health how to access various support groups and voluntary organisations. They had a system in place to follow up patients who had attended accident and emergency (A&E) when they may have been experiencing poor mental health.

Summary of findings

What people who use the service say

From reviewing a number of information sources we found satisfaction with patient experience. The information we reviewed were comments made by seven patients visiting the practice, discussion with three members of the Patient Participation Group and 17 Care Quality Commission comment cards completed by patients who visited the practice. We looked at the NHS Choices website, the national GP patient survey results and reviewed responses from the friends and family test conducted by the practice.

During our inspection we spoke with 10 patients who were very complimentary about the practice. Patients commented that treatment received was very good and GPs listened to patients and patients felt involved in their treatment. Patients said they were seen the same day for urgent appointments and children were seen promptly.

We received 17 comment cards which had been completed by patients who visited the practice. We found 15 out of the 17 comment cards stated that patients were highly satisfied with all the staff at the practice and that they provided exceptional care.

We reviewed NHS Choices (a forum for patients to publicly provide their views about the practice and where the practice can respond to these views). We saw there had been no patient comments made about the practice in the last year.

The practice showed us the results from the friends and family test during the period of December to June 2015. We saw 284 patients had completed the survey and 92% of these were either extremely likely or very likely to recommend the practice to their friends and family.

We reviewed the national GP patient survey for the periods of January to March and July to September 2014. This is a national survey sent to patients by an independent company on behalf of NHS England. We saw 114 patients had completed the surveys from the 293 sent. In summary and in comparison to the Somerset Clinical Commissioning Group (CCG) and national average, 90.9% of patients were highly satisfied with their overall experience of the practice and 96.1% of patients found the receptionists helpful. Patients were least satisfied with the ability to see their preferred GP and being involved in decisions about their care by the GP. The survey results showed patients were highly satisfied in comparison with national and local results with the appointment system in all areas.

Areas for improvement

Action the service SHOULD take to improve

- Ensure there is an effective monitoring system in place to monitor staff training including information of what is expected of staff to complete on a mandatory basis and how often.

Abbey Manor Medical Practice

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Inspector and GP specialist advisor.

Background to Abbey Manor Medical Practice

We inspected the location of Abbey Manor Medical Practice, The Forum, Abbey Manor Park, Yeovil, Somerset, BA21 3TL, where all the registered regulated activities were carried out. Hendford Lodge Medical Practice was also run by the same partnership as Abbey Manor Medical Practice under the Diamond Health Group. This location is registered separately and was not inspected as part of this inspection.

The practice serves approximately 2850 patients who live in Yeovil and the surrounding areas. The national general practice profile shows the practice has a higher than England average population of female patients from birth to 9 years old, 25 to 39 years and 85 years and over. The male patient population was higher than average from birth to 14 years and 20 years to 24 years old. The practice has below the national and local average for females between 75 to 84 years and male and females from 55 to 69 years old. The practice sited in one of the least deprived areas in their patient catchment area.

There were 10 GPs within the partnership who run the two practices Abbey Manor Medical Practice and Hendford Lodge Medical Centre under the name of Diamond Health Group. At Abbey Manor Medical Practice two of the 10 GP partners are based at this practice to provide continuity of care to patients. There was one male and one female GP. The GPs worked the equivalent of 1.25 full time hours with one GP working one a day week and the other working four days a week. Other GPs in the partnership cover any absences, such as annual leave or training days, to avoid using locum cover and to provide continuity of care.

The nursing team also worked in both medical practices. A nursing manager oversees the nursing team within both practices and provides patient care. There were six practice nurses employed over both locations with two practice nurses providing the main nursing care at Abbey Manor Medical Practice. There were also five healthcare assistants employed over both locations with two of these providing the majority of health care assistant at Abbey Manor Medical Practice.

The practice has a Personal Medical Services contract with NHS England (a locally agreed contract negotiated between NHS England and the practice). The practice is contracted for a number of enhanced services including extended hours access, facilitating timely diagnosis and support for patients with dementia, minor surgery, patient participation, immunisations and remote care monitoring. The practice refers their patients to NHS 111 operated by South Western Ambulance Service for out-of-hours services to deal with urgent needs when the practice is closed. The service provider is due to change as of 1 July to Somerset Doctors Urgent Care, operated by Vocare.

Additional services are provided from the practice premises including South Somerset Leg Ulcer Service and OASIS East orthopaedic interface clinic. Patients can also access weekly appointments with a dietician within the practice.

Detailed findings

The practice has patients registered at one nursing home.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. 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

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 patient's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of patients and what good care looks like for them. The population groups are:

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

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. Prior to our inspection we had spoken with the Somerset Clinical Commissioning Group, NHS England local area team and Healthwatch Somerset. We carried out an announced visit on the 24 June 2015. During our visit we spoke with 10 staff including two GP's, the practice manager, assistant practice manager, the nursing manager, two health care assistants and two receptionists/administrators.

Good

Are services safe?

Our findings

Safe track record

The practice prioritised safety and used a range of information to identify risks and improve patient safety, such as, reporting incidents and reviewing 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, a patient had an accident and had fallen over outside the practice. The GP was on hand to assist the patient and the incident was discussed at a team meeting to reduce the risk of it from happening again. We heard of another incident which involved a vulnerable patient and how they were referred to the appropriate authorities to ensure their safety.

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 ten significant events that had occurred during the last year and saw these were followed appropriately. Significant events were discussed as and when they occurred with appropriate members of the staffing team. This worked well for this practice as they had a small staff team. There was evidence the practice had learned from these and that findings were shared with relevant staff. Staff, including receptionists, administrators and nursing staff, knew how to raise an issue for consideration at team meetings and they felt encouraged to do so. The practice had a system to manage and monitor incidents. Staff accessed incident forms on the practice intranet and sent completed forms to the practice manager. We found the practice fed back to other authorities when necessary to highlight any learning which would be appropriate to them.

Reliable safety systems and processes including safeguarding

The practice had systems to manage and review risks to vulnerable children, young people and adults. We saw training records which indicated all staff had received level three child protection training last year and staff received vulnerable adults training on a two yearly basis. Staff had access to a detailed policy on vulnerable adults which described how to recognise abuse and what action to take. Staff spoken with knew how to recognise signs of abuse in older patients, 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 for external authorities were easily accessible on the staff intranet. Clear policies were available and up to date for staff to refer to on safeguarding children and vulnerable adults and had been reviewed in the last year.

The practice had appointed dedicated GPs leads in safeguarding vulnerable adults and children. They had been trained in both adult and child safeguarding and could demonstrate they had the necessary competency and training to enable them to fulfil these roles.

There was a system to highlight vulnerable patients on the practice's electronic records. This included information to make staff aware of any relevant issues when patients attended appointments; for example children subject to child protection plans. There was active engagement in local safeguarding procedures and effective working with other relevant organisations including health visitors and the local authority.

The practice used chaperones to act as a safeguard and witness for a patient and health care professionals during a medical examination or procedure. All nursing staff, including health care assistants, had been trained to be a chaperone. Receptionists had also undertaken training and acted as a chaperone if nursing staff were not available. Staff understood their responsibilities when acting as chaperones, including where to stand to be able to observe the examination. 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). Staff would not act as a chaperone until the DBS check had been completed.

Medicines management

We checked medicines stored in the treatment rooms and found they were stored securely and were only accessible to authorised staff. The medicines kept in lockable refrigerators but which were not routinely locked securely by staff. The nursing manager confirmed the process would be changed following our inspection to ensure these were

locked routinely by staff. There was a protocol for ensuring that medicines were kept at the required temperatures, and which described the action to take in the event of a potential failure. Records showed refrigerators temperature checks were carried out which ensured the equipment was maintaining the correct temperature for the safe storage of medicines.

Processes were in place to check medicines were within their expiry date and suitable for use. The majority of medicines we checked were within their expiry dates. However, we did find out of date vaccinations. We checked no patients had received a dose of this vaccine since it had passed its expiry date. Vaccines were routinely checked for expiry on a weekly basis. However, these vaccines had been missed. Within 24 hours of our inspection the practice had changed it system and included a specific record for checking the expiry of vaccines. This was also treated as a significant event and a meeting had been held to discuss the incident. Expired and unwanted medicines were disposed of in line with waste regulations.

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

There was a system in place for the management of high risk medicines and other disease modifying drugs, which included regular monitoring in accordance with national guidance. Appropriate action was taken based on the results.

The practice nurses used Patient Group Directions (PGDs) to administer vaccines and other medicines that had been produced in line with legal requirements and national guidance. We saw sets of PGDs had been reviewed in the last year and signed by staff administering the vaccines.

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 infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement necessary measures. The policy was up to date and had been reviewed in the last year. Protocols were in place to provide guidance on the procedure for needle stick injuries, training and audit requirements, hand washing procedures and infection control guidelines for nursing procedures. We saw personal protective equipment was available in treatment rooms including disposable gloves. Disposable curtains were changed every six months and coverings for couches were available for staff to use and changed after each patient use. There was a separate room used for minor surgery treatment, such as joint injections and family planning procedures.

Staff had received training in infection control from the lead for infection control. They had attended training which they had disseminated to other nurses upon their return. There had been no formal training for other staff to complete, however there was a plan in place to ensure staff received formal training. All staff were required to read the infection control policy as part of their induction process.

We saw an infection control audit had been completed in February 2015 and areas for improvement had been highlighted. All recommendations following the audit had been completed. The practice had recently replaced the flooring within the communal areas, which was previously carpeted, with vinyl non-slip flooring.

The practice had carried out a risk assessment through advice from their external maintenance provider in January 2015 for the management, testing and investigation of legionella (a bacterium which can contaminate water systems in buildings). We saw records which confirmed the practice was carrying out regular checks in line with this risk assessment to reduce the risk of infection to staff and patients.

Equipment

Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records which confirmed this, for example, we saw evidence of calibration of relevant equipment; for example weighing scales, electrocardiogram, spirometers and blood pressure measuring devices.

Staffing and recruitment

Good

Are services safe?

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 there were enough staff 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. Rotas were sent to staff a month in advance and any evident gaps for cover were arranged with other available staff. If GPs or nursing staff had unplanned absence this was covered by other GPs or nursing staff from the shared staffing group at Hendford Lodge Medical Practice. 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.

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 checks of the building, the environment, staffing and equipment. Health and safety information was displayed for staff to see and there was an identified health and safety representative.

We saw a fire risk assessment had been completed in January 2015. We saw completed fire logs including emergency lighting and fire alarm checks and fire extinguishers had been regularly checked by an external fire safety company. The practice had fire drills and tested the fire alarms regularly. Staff had received fire safety training approximately two years ago and new staff were shown fire procedures when they started. The practice also had a trained fire marshal and had completed their training in June 2014.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We were informed all staff had received training in basic life support. Emergency equipment was available including access to oxygen, pulse adult and paediatric oximeters 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 on a weekly basis.

Emergency medicines were easily accessible to staff in a secure area of the practice and all staff knew of their location. These included those for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice did not routinely hold stocks of medicines for the treatment of severe acute pain. We were assured that a full risk assessment had been undertaken and a protocol was in place to manage this. The practice told us they had supplies of pain relief for moderate pain and were near to an accident and emergency department. The practice did not have all treatment options available for chest pain, acute severe asthma and severe anaphylaxis and bradycardia (potential complications during family planning procedures and minor surgery). Within 24 hours of our inspection the practice had reviewed its procedures and medicines to treat these conditions were provided within their emergency medicines list. 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. The business continuity plan had been reviewed in the last year. Each risk had 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, for example, contact details of a heating company if the heating system failed.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

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

We discussed with the practice manager, GP and nurse how NICE guidance was received into the practice. They told us this was disseminated to staff usually by the practice manager or GP lead or nursing manager. The practice had a clinical effectiveness team which included GPs from both practices. All relevant new guidelines were discussed at monthly meetings and where necessary new protocols and procedures were discussed. Staff we spoke with all demonstrated a good level of understanding and knowledge of NICE guidance and local guidelines. For example, the nursing manager told us of guidance changing for hypertension and the practice protocol had changed to reflect the changes in this guidance.

Staff described how they carried out comprehensive assessments which covered all health needs and was in line with these national and local guidelines. They explained how care was planned to meet identified needs and how patients were reviewed at required intervals to ensure their treatment remained effective.

The GPs told us they lead in specialist clinical areas such as family planning and musculoskeletal orthopaedics. Because Abbey Manor Medical Practice was linked with Hendford Lodge Medical Practice GPs and nursing staff were able to contact all 10 GPs within the partnership for advice and support, which increased availability of areas of expertise and knowledge they could call upon. GPs and nursing 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.

We saw that after patients were discharged from hospital they were followed up to ensure that all their needs were continuing to be met.

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 patient's care and treatment, and their outcomes, was routinely collected and monitored and this information used to improve care. Staff across the practice had key roles in monitoring and improving outcomes for patients. These roles included data input, scheduling clinical reviews, and managing child protection alerts and medicines management.

The practice had a clinical review programme organised through the clinical effectiveness team (who cover both practices). Each month a GP lead would audit a specific area, such as diabetes, epilepsy, asthma and cancer. We saw four clinical audit records which had been completed in the last year. This included chronic pulmonary obstructive disease audit and a gout audit (acute episodes of pain in joints). The gout audit reviewed 50 patients to see if particular levels were meeting current guidelines, it was found 30.6% of patients did and the standard was 50%. In comparison to 2012/2013 and 2013/2014 figures the practice had improved on this area. Figures also showed a decrease of gout attacks in the last year in comparison to 2012/2013 and 2013/2014. The audit had recommendations for further improvement and a presentation was provided to GPs following the audit to ensure there was a consistent understanding of what standards should be followed.

The GPs told us clinical audits were often linked to medicines management information, safety alerts or as a result of information from the Quality and Outcomes Framework (QOF) or Somerset Practice Quality Scheme (SPQS). (QOF is a voluntary incentive scheme for GP practices in the UK. The scheme financially rewards practices for managing some of the most common long-term conditions and for the implementation of preventative measures. SPQS is a locally based scheme aimed at improving services based on local patient's needs). For example, the practice held regular medicines management meetings with the GPs and the community

Good

Are services effective?

(for example, treatment is effective)

pharmacist, who worked regularly in the practice. This enabled them to decide on which audits they would be completing following a review of areas they could improve upon.

The practice also used the information collected for the QOF, SPQS and performance against national screening programmes to monitor outcomes for patients. This practice was an outlier for QOF (or other national) clinical targets, they achieved 63.3% of the total QOF target in 2014, which was below the national average of 94.2%. This was accounted for by the practice participating in the Somerset Practice Quality Scheme (SPQS) and therefore was not providing all QOF data. The practice was still continuing to monitor long term conditions through their nurse clinics and alerts on the system. However, this was not reflected under the QOF data. Specific examples to demonstrate this included:

- Performance for diabetes related indicators were worse than the national average.
- The percentage of patients with hypertension having regular blood pressure tests was similar to the national average.
- Performance for mental health related indicators were worse than the national average apart from one rating for recording smoking status of these patients which was similar to national average.
- The dementia diagnosis rate was similar to expected to the national average

The practice was aware of all the areas where performance was not in line with national figures and we heard how these were being addressed. For example, the reasoning for the lower diabetes ratings was because the practice had changed recall systems, the specialist diabetes nurse had left the practice and the practice had moved to using SPQS. All of these events had impacted on performance figures. The practice was monitoring their system to ensure patients received the appropriate treatment at the right time.

The practice's prescribing rates were similar to national figures. Staff regularly checked patients had their medicines reviewed, particularly for high risk medicines when checking repeat prescription requests. The IT system flagged up relevant medicines alerts when the GP was prescribing medicines.

The practice had a palliative care register and there were 18 patients on this register. The lead GP attended regular six weekly multidisciplinary meetings to discuss the care and support needs of patients and their families. The patient record system was colour coded to indicate the patient's status and the level of care intervention required. The majority of palliative care was provided to patients in the local nursing home and regular contact was made to provide on-going care.

The practice had a similar rate to expected number of emergency admissions to hospital. They kept a register of patients identified as being at high risk of admission to hospital and patients on this list were discussed regularly at multi-disciplinary meetings involving health visitors and district nurses.

Structured annual reviews were also undertaken for patients with long term conditions such as asthma, diabetes and heart failure.

The practice hosted a specialist leg ulcer clinic for patients requiring complex dressings and treatment. The clinic was run by four trained nurses and two health care assistants employed by the partnership. They will see patients within the South Somerset area including Yeovil, Wincanton and Langport. They provided approximately 250 to 300 treatments per month. They were supported by a vascular surgeon and a tissue viability nurse and received regular wound care updates and training. The nursing manager told us the clinic had been successful because patients who had wounds for a number of years were now having successful healing results.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We were informed by the practice manager that staff were up to date with annual basic life support training. Training days for basic life support training were changed each year to enable the majority of staff to attend. Training was provided by an external company who provided advice on life support and how to use all equipment and medicines available in the practice in an event of an emergency. There was no formal system for the practice manager to monitor training for all staff groups at one time. The system used to monitor training for individuals highlighted when courses were overdue. However, we were unable to clearly determine what training all staff had completed and when. The practice

preferred using practical training sessions for staff rather than online training. Recently they had an external company provide training on fire safety and they planned to provide training on equality and diversity in July 2015. Reception staff had recently had training on customer services. We were informed the practice was looking at some of its training being completed through an online company.

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

We saw records of completed appraisals and staff were expected to receive an appraisal annually. Appraisals identified learning needs from which action plans were documented. Our interviews with staff confirmed the practice was proactive in providing training and funding for relevant courses, for example the practice cleaner had been given support and training to become a health care assistant. The practice also employed an apprentice to support the practice administration tasks which had enabled more team work with the receptionist/ administrators.

The practice employed a nursing manager who could also prescribe medicines for treating minor illnesses. The nurse received regular clinical supervision from the senior partner GP to ensure they were continually supported in this role.

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, the nursing manager had received additional training in managing leg ulcers as they treated patients within the practice at a weekly clinic.

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. They 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. Staff knew their responsibilities in passing on, reading and acting on any issues raised from these communications. Out-of hour's reports, 111 reports and pathology results were all seen and addressed by a GP the same day. Discharge summaries and letters from outpatients were usually seen and action taken the same day. 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. Emergency hospital admission rates for the practice were relatively low at 9.4% compared to the national average of 13.6%.

The practice held monthly multidisciplinary meetings to discuss patients with complex needs. For example, those with multiple long term conditions, mental health problems, patients from vulnerable groups, those with end of life care needs or children on the at risk register. These meetings were attended by district nurses and health visitors, when possible. Staff felt this system worked well and if other professionals were unable to attend they would contact them by phone. Care plans were in place for patients with complex needs and shared with other health and social care workers as appropriate.

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. (Summary Care Records provide faster access to key clinical information for healthcare staff treating patients in an emergency or out of normal hours).

The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients'

Good

Are services effective?

(for example, treatment is effective)

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.

Consent to care and treatment

We found staff were aware of the Mental Capacity Act 2005 and their duties in fulfilling them. All the GPs we spoke with understood the key parts of the legislation and were able to describe how they implemented them in their practice. 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. All GPs and nurses spoken with 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).

Consent for particular treatments was recorded on the patient record system, for example, immunisations. Written consent was taken for joint injections and family planning interventions.

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 opportunistic 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.

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 its patients over the age of 16 and actively offered nurse-led smoking cessation clinics to these patients. We saw three out of 17 patients who had signed up for smoking cessation had been successful. In total there were 160 patients who had been seen for smoking cessation advice and 20 of these had stopped smoking.

A diabetes information evening was held in September 2014 which was attended by GPs, nurses and a small group of patients. Patients were able to share their experiences with others including those who had been diagnosed recently.

The practice was in discussion with the midwifery services to provide a drop in/coffee informal meeting bi-monthly with expectant mothers.

The practice was working with the local ProActive service and the practice have supported their 'pound for pound' initiative which aims to provide £1 funding to the local community for every pound (in weight) lost by those who join the initiative.

The practice's performance for the cervical screening programme was 80.33%, which was similar to the national average of 81.89%. There was a policy to offer telephone reminders for patients who did not attend for their cervical screening test. A practice nurse had responsibility for following up patients who did not attend. The practice also encouraged its patients to attend national screening programmes for bowel cancer and breast cancer screening. We were told 175 patients had received bowel cancer screening in the last year. We were also told 35% of eligible patients had breast cancer screening.

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 over 65s were 86.26%, and at risk groups 67.39%. These were above national averages, which were 73.24% and 52.29% respectively.
- Childhood immunisation rates for the vaccinations given to under twos ranged from 92.9% to 100% and five year olds from 91.7% to 100%. These were either above or comparable to CCG averages.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice from the national GP patient survey from 2014 gaining views from 114 patients.

The evidence from national patient survey showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect by the nurses. However, patients were less satisfied with their interactions with the GPs. For example:

- 81.8% said the GP was good at listening to them compared to the CCG average of 90% and national average of 87.2%.
- 85.1% said the GP gave them enough time compared to the CCG average of 88.5% and national average of 85.3%.
- 93.8% said they had confidence and trust in the last GP they saw compared to the CCG average of 94.8% and national average of 92.2%
- 80% said the last nurse they saw was good at listening to them compared to the CCG average of 81.5% and national average of 79.1%.
- 75.8% said the last nurse they saw gave them enough time compared to the CCG average of 82.5% and national average of 80.2%.
- 85.9% said they had confidence and trust in the last nurse they saw compared to the CCG average of 88% and national average of 85.5%

The practice had discussed the GP patient survey results with the patient participation group because they were not comparative with results from the friends and family test and patient complaints. They informed us they would be conducting a specific survey on the areas where patients were least satisfied to see if improvements could be made.

Patients completed 17 CQC comment cards to tell us what they thought about the practice. We found 15 out of the 17 comment cards showed patients were highly satisfied with all the staff at the practice providing exceptional care. Patients said they felt the staff were efficient, helpful and caring and treated them with dignity and respect. We also spoke with 10 patients on both days of our inspection. All told us they were satisfied with the care provided by the practice and said their dignity and privacy was respected.

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

We saw staff were careful when discussing patients' treatments so confidential information was kept private. The majority of patient telephone calls were taken in an office away from the waiting area and reception. There was a sign up for patients to ask them to provide the patient in front space to increase confidentiality for patients. There was also a separate room that could be used to enable receptionists to speak with patients confidentially to help keep patient information private. Additionally, 96.1% of respondents to the national patient survey said they found the receptionists at the practice helpful compared to the CCG average of 89.1% and national average of 86.9%.

Care planning and involvement in decisions about care and treatment

The patient survey information we reviewed showed patients who responded were average in comparison with national results in regard to questions about their involvement and explanations in planning and making decisions about their care and treatment with nurses and generally lower than average for GPs. For example:

- 79.8% said the last GP they saw was good at explaining tests and treatments compared to the CCG average of 85.6% and national average of 82%.
- 67.1% said the last GP they saw was good at involving them in decisions about their care compared to the CCG average of 78.4% and national average of 74.6%.
- 78.2% said the last nurse they saw was good at explaining tests and treatments compared to the CCG average of 79.2% and national average of 76.7%.
- 66.2% said the last nurse they saw was good at involving them in decisions about their care compared to the CCG average of 67.4% and national average of 66.2%.

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

Good

Are services caring?

consultations to make an informed decision about the choice of treatment they wished to receive. Patient feedback on the comment cards we received were positive. However, one patient felt they were not listened to by the GP.

Staff told us that translation services were available for patients who did not have English as a first language.

Patient/carer support to cope emotionally with care and treatment

The GP patient survey information we reviewed showed patients were positive about the emotional support provided by the practice and was average in comparison to national ratings for nurses and was lower than average for GPs. For example:

- 75.2% said the last GP they spoke to was good at treating them with care and concern compared to the CCG average of 86.1% and national average of 82.7%.
- 80.8% said the last nurse they spoke to was good at treating them with care and concern compared to the CCG average of 80.8% and national average of 78%.

The patients we spoke with on the day of our inspection and the comment cards we received were felt GPs and nursing staff treated them with care and concern.

Notices in the patient waiting room and on the patient website also told patients how to access a number of support groups and organisations, such as for carers.

The practice supported carers by providing advice and support information within the waiting area of the practice. The also had a carers champion and dementia champion. The carers champion attended carers' events with other champions in the area to increase their knowledge of local services available. In total they had 18 carers registered with them.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

We found the practice was responsive to patient's needs and had systems in place to maintain the level of service provided. The needs of the practice population were understood and systems were in place to address identified needs in the way services were delivered.

The NHS England area team and Somerset Clinical Commissioning Group (CCG) told us the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised. There was an orthopaedic service provided by the practice called Oasis East Clinics which provided investigative, diagnostic and some cases treatment for musculoskeletal conditions to reduce time the patient would have waited if referred to hospital. A GP with specialist training lead the clinic with support and advice from Orthopaedic surgeons.

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). For example, the waiting area had been improved by including relevant patient leaflets and reading materials. There had been an event aimed for the Polish community to improve health care and encourage health promotion amongst this group.

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 complex needs and were highlighted on the system for staff to recognise. The majority of the practice population were English speaking patients with the Polish language being the next most widely used language. The practice had access to online and telephone translation services were available if they were needed.

The premises and services had been designed to meet the needs of patients with disabilities. Patients who were hard of hearing had access to a hearing loop. The practice was accessible for wheelchair users including accessible consulting and treatment rooms, a lower desk at reception, male and female accessible toilets and baby changing facilities. The waiting area had plenty of space for wheelchairs and prams. This made movement around the practice easier and helped to maintain patients' independence. The practice also had two dedicated parking spaces for wheelchair users.

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

Access to the service

The practice telephone lines were open from 8:30am until 6:30pm Monday to Friday. Routine appointments were available from 9am until 11:30am and 3:30 until 5:40pm Monday to Friday. Telephone consultations, same day appointments and home visits were made between and after surgeries. Extended hours appointments were offered on Monday and Thursday until 7pm. Arrangements were in place for patients to contact other services when the practice was not open. The out of hour's service provided care to patients from 6:30pm until 8am. Another local practice took calls for the practice between 8am and 8:30am.

Comprehensive information was available to patients about appointments on the practice website. This included GP appointment sessions, 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, an answerphone message gave the telephone number they should ring depending on the circumstances. Information on the out-of-hours service was provided to patients.

Regular visits were made to a nursing home specialising in dementia care, where the majority of patients were registered at the practice. Weekly visits were made to the local residential home. These visits took place on a specific day each week, by a named GP for those patients who needed to be seen. If these patients required an urgent home visit then this was also accommodated.

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:

- 79.6% were satisfied with the practice's opening hours compared to the CCG average of 77.5% and national average of 75.7%.

Good

Are services responsive to people's needs?

(for example, to feedback?)

- 87.8% described their experience of making an appointment as good compared to the CCG average of 79.8% and national average of 73.8%.
- 88.8% said they usually waited 15 minutes or less after their appointment time compared to the CCG average of 69.5% and national average of 65.2%.
- 87% said they could get through easily to the surgery by phone compared to the CCG average of 76.8% and national average of 71.8%.
- 80% said they did not normally have to wait too long to be seen compared to the CCG average of 63.1% and national average of 57.8%.

Patients we spoke with were satisfied with the appointments system and said it was easy to use. They confirmed they could see a GP 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 GP if there was a wait to see the GP of their choice. Comments received from patients also showed that patients in urgent need of treatment had often been able to make appointments on the same day of contacting the practice.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. There was a designated responsible person who handled all complaints in the practice. We saw information was available to help patients understand the complaints system on the practice website and in a practice complaints and compliments leaflet. This information provided details on what the patient could expect in relation to response timescales, how to complain externally to the appropriate authorities if they were dissatisfied with the practice response and details of advocacy services to support patients to complain. 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 saw 10 complaints had been received in the last 12 months and we read two complaints in detail and found they had been satisfactorily handled.

The practice reviewed complaints annually to detect themes or trends. We read the report for the last year and saw there were no themes from complaints. However, lessons learned from individual complaints had been acted on and improvements made to the quality of care as a result.

Are services well-led?

Good

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

Our findings

Vision and strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The practice vision and values included providing high quality care, treatment and support to all our patients. The practice values were clearly displayed in the staff room. Staff also had access to the practice vision and values through the staff handbook. The partners regularly met on a monthly basis to discuss business needs and future plans. They planned to hold a meeting to development a business plan for the next year, three years and five years.

We spoke with 10 members of staff and they all knew and understood the vision and values and knew what their responsibilities were in relation to these.

Governance arrangements

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 10 of these policies and procedures and saw they 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 GP partner was the lead for safeguarding. We spoke with 10 members of staff and they were all clear about their own roles and responsibilities. They all told us they felt valued, well supported and knew who to go to in the practice with any concerns.

The GPs and practice manager took an active leadership role for overseeing that the systems in place to monitor the quality of the service were consistently being used and were effective. This included using the Somerset Practice Quality Scheme (SPQS) and Quality and Outcomes Framework to measure performance. We heard that QOF and SPQS data was regularly discussed at monthly team meetings and action plans were produced to maintain or improve outcomes.

The practice had an on-going programme of clinical audits which it used to monitor quality and systems to identify where action should be taken. For example, decisions on which audits should be conducted were discussed regularly at monthly clinical effectiveness team meetings.

Evidence from other data from sources, including incidents and complaints was used to identify areas where 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 practice regularly submitted governance and performance data to the CCG.

The practice identified, recorded and managed risks. They had carried out risk assessments where risks had been identified and action plans had been produced and implemented, for example infection control audits had been completed and actions arising from the audit had been addressed. The practice monitored risks on a monthly basis to identify any areas that needed addressing. The practice held monthly staff meetings where governance issues were discussed including performance, quality and risk.

The practice manager was responsible for human resource policies and procedures. We reviewed a number of policies, such as recruitment of staff, which were in place to support staff. We heard there was an electronic staff handbook that was available to all staff, which included sections on 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 in the staff handbook and electronically on any computer within the practice.

Leadership, openness and transparency

Staff told us the partners in the practice were visible, 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.

Staff meetings were held monthly in the practice. These meetings included a training element and were allocated a half day, which provided an opportunity for staff to attend specific training events including chaperoning, safeguarding, fire safety and basic life support. This would not always include all staff depending on the topic, however if relevant, all staff would attend. In addition to this there were separate role specific team meetings held, such as nursing, administration and management.

Are services well-led?

Good

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

Staff told us there was an open culture within the practice and they had the opportunity to raise any issues at team meetings and were confident in doing so and felt supported if they did. The practice manager also had an open door policy, and staff told us they were easily able to approach their manager to raise concerns. Staff said they felt respected, valued and supported, particularly by the partners in the practice.

Practice seeks and acts on feedback from its patients, the public and staff

The practice encouraged and valued feedback from patients. They had gathered feedback from patients through the patient participation group (PPG), patient surveys and complaints received. They had recently started a new active PPG which included seven representatives from the practice including various population groups; older patients and working age patients. The practice had met with the PPG twice since its re-launch in March 2015. The PPG had initiated an event specifically for the Polish population; patients or locals in the community. The event had been successful and had up to 35 attendees, some of which were not registered with the practice who have since registered. The event was to provide additional understanding of the NHS service and what to expect from it. The aim was to improve health care and knowledge amongst the group. The event also had interpreters available for patients and others to speak with. The practice had also started advertising on social media, an idea taken from a member of the PPG.

We heard the practice had reviewed its' results from the national GP survey with the PPG to see if there were any areas that needed addressing. The practice was lower than national average in some areas such as GP involvement, explanations, listening and treating patients with care and concern. Because there was no immediate reason why this way the practice decided it would conduct a question specific survey on these areas to a selection of patients to see why patients felt this way. The practice was actively encouraging patients to be involved in shaping the service delivered at the practice.

The practice had also gathered feedback from staff through team meetings, appraisals, half day training days, informal discussions and an open door policy with the practice manager and the deputy practice manager. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. They said they felt involved and engaged in the practice to improve outcomes for both staff and patients.

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 read four staff files and saw that regular appraisals took place which included a personal development plan. Staff told us the practice was very supportive of training and they had staff training sessions which guest speakers and trainers attended.

The practice had completed reviews of significant events, complaints and other incidents and shared them with staff at meetings to ensure the practice improved outcomes for patients. We saw that processes and procedures were updated and latest guidance reflected, to ensure patients received best practice care.