Dunster Surgery

Inspection 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 location	Outstanding ☆
Are services safe?	Good ●
Are services effective?	Good ●
Are services caring?	Outstanding ☆
Are services responsive?	Good ●
Are services well-led?	Outstanding ☆

Overall summary

This practice is rated as outstanding overall. (Previous rating May 2015 – Outstanding)

The key questions at this inspection are rated as:

Are services safe? – Good

Are services effective? – Good

Are services caring? – Outstanding

Are services responsive? – Good

Are services well-led? - Outstanding

We carried out an announced comprehensive inspection at Dunster Surgery and Porlock Medical Centre (the branch surgery) on 17 & 18 October 2018 as part of our inspection programme.

At this inspection we found:

- The practice had a clear vision which had quality and safety as its top priority. High standards were promoted and owned by all practice staff with evidence of team working across all roles.
- The practice had clear systems to manage risk so that safety incidents were less likely to happen. When incidents did happen, the practice learned from them, improved their processes and set review dates.
- The practice had an open culture in which all safety concerns raised by staff and people who use services were valued as integral to learning and improvement. They were innovative and implemented systems and processes to support them to identify and minimise risks to patients.
- There was a well-embedded culture of high quality sustainable care which included a strong focus on continuous learning and improvement, quality improvement such as clinical audit and reviews of the effectiveness and appropriateness of the care they provided across all levels of the organisation. This ensured that care and treatment was delivered according to evidence- based guidelines.
- Staff involved and treated patients with compassion, kindness, dignity and respect. We saw that the practice cared for the population through provision of additional services such as those to enable end of life patients to remain at home. This included funding a night sitter nursing service for the local population and direct contact with a practice GP out of hours.
- There was compassionate, inclusive and effective leadership with an embedded system of progression and development which aimed to ensure that there was a whole team approach to service delivery. Practice leaders prioritised compassion and support towards their staff and other health professional's wellbeing.
- Patients found the appointment system easy to use and reported that they were able to access care when they needed it. They responded positively to their overall experience at the practice.

The areas where the provider **should** make improvements are:

- Dispose of medicine receptacles in line with safe management of healthcare waste guidance.
- Review and continue to monitor cervical smear screening to meet Public Health England screening rates.

Professor Steve Field CBE FRCP FFPH FRCGPChief Inspector of General Practice

Please refer to the detailed report and the evidence tables for further information.

Population group ratings

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

Our inspection team

Our inspection team was led by a Care Quality Commission (CQC) lead inspector**.** The team included a GP specialist adviser and a member of the CQC medicines team.

Background to Dunster Surgery

Dunster and Porlock Surgeries (provider) is registered with CQC for the location Dunster Surgery. The provider provides primary medical services to approximately 6100 patients living in Dunster, Porlock and the surrounding rural area of Exmoor national park which encompasses Devon and Somerset, which brings its own challenges of divided healthcare services over two counties and 100 square miles. Since our previous inspection and following the closure of a local surgery, Dunster Surgery added 1700 people to their patient population. The practice has a General Medical Services (GMS) contract to deliver primary health care to the local population.

The service operates from a purpose-built building in Dunster where they provide a dispensary service: West Street Dunster, Somerset TA24 6SN. We visited this address and the branch surgery: Porlock Medical Centre, Porlock, TA24 8PJ as part of our inspection. Further information about the practice can be found at www.dunsterandporlocksurgeries.co.uk

The Index of Multiple Deprivation 2015 is the official measure of relative deprivation for small areas in England. The deprivation decile for this area is five with one being the least deprived and 10 the most. The practice had a higher than average number of patients aged over 65 which equates to 32% of the practice population compared with the local average of 24% and national of 17%. The percentage of patients aged over 75 was 13% compared to 10% (local) and 7% (national). Patients aged 0 to 4 years was 3.3% (local 4.9% national 5.8%) and aged 5-14 years was 5.4% (local 11.1% national 11.8%).

The Partnership is registered with the CQC in respect of the regulated activities: Diagnostic and screening procedures; Family planning; Maternity and midwifery services; Surgical procedures and Treatment of disease, disorder or injury.

The practice partnership consists of three male GP partners and two salaried GPs (male and female). The practice team includes five practice nurses, one of which is an independent prescriber, a complex care nurse in a home support role, two practice managers, an associate practitioner and a health care assistant, administrative and dispensary staff.

The practice is a training practice for trainee GPs. At the time of the inspection, a GP registrar (a trainee GP) was working at the practice.

The practice has opted out of providing Out Of Hours services to their own patients. Patients can access a local Out Of Hours GP service via NHS 111.

Good

Are services safe?

The practice was rated as good for providing safe services.

Safety systems and processes

The practice had clear systems to keep people safe and safeguarded from abuse.

- The practice had appropriate systems to safeguard children and vulnerable adults from abuse. All staff received up-to-date safeguarding and safety training appropriate to their role. The clinical lead for safeguarding had completed level 4 competencies for safeguarding children in order to improve mentoring and supervision of clinical staff and for assurance around record keeping (which was above the expected training for their role). They knew how to identify and report concerns. Learning from safeguarding incidents were available to staff.
- The practice had undertaken a local pilot 'My concern' (software for recording and managing all safeguarding concerns in any educational setting). Following the pilot, the practice was exploring possibilities with local schools of using an alternative system of joined up health and education communication for effective partnership working, and an integrated health and education system.
- Staff who acted as chaperones were trained for their role and had received a Disclosure and Barring Service (DBS) check. (DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.)
- Staff took steps, including working with other agencies, to protect patients from abuse, neglect, discrimination and breaches of their dignity and respect.
- The practice carried out appropriate staff checks at the time of recruitment and on an ongoing basis.
- There was an effective system to manage infection prevention and control. The practice produced an annual infection, prevention and control statement.
- The practice had arrangements to ensure that facilities and equipment were safe and in good working order.
- Arrangements for managing waste and clinical specimens kept people safe.

Risks to patients

There were adequate systems to assess, monitor and manage risks to patient safety.

- Arrangements were in place for planning and monitoring the number and mix of staff needed to meet patients' needs, including planning for holidays, sickness, busy periods and epidemics.
- There was an effective induction system for temporary staff tailored to their role.
- The practice was equipped to deal with medical emergencies and staff were suitably trained in emergency procedures.
- Staff understood their responsibilities to manage emergencies on the premises and to recognise those in need of urgent medical attention. Clinicians knew how to identify and manage patients with severe infections including sepsis. There were clinical flow charts in place to triage and treat clinical emergencies including the sepsis six (an operational guide for clinicians when managing a possible sepsis). Administrative staff had received additional training (2017) in 'red flags' such as managing chest pain and the National Early Warning Score (NEWS) for sepsis.
- When there were changes to services or staff the practice assessed and monitored the impact on safety.
- The leadership team demonstrated their openness with the patient participation group (PPG) to discuss risks, incidents and improvements within their quarterly report to the group. This allowed the PPG to question and any raise concerns from a patients' perspective.

Information to deliver safe care and treatment

Staff had the information they needed to deliver safe care and treatment to patients.

- The comprehensive care records we saw showed that information needed to deliver safe care and treatment was available to staff. The practice was able to demonstrate improvement through audit in 12 aspects of recording of clinician notes within patient records to ensure they were within NHS England criteria and met General Medical Council (GMC) and Royal College of General Practice (RCGP) best practice. For example, coherent and well-structured patient records, a record of clinical examination findings, an up to date medicines review and appropriate diagnostic decisions based on the information acquired.
- The practice had systems for sharing information with staff and other agencies to enable them to deliver safe care and treatment.
- Clinicians made timely referrals in line with protocols.

Good

Are services safe?

Appropriate and safe use of medicines

The practice had reliable systems for appropriate and safe handling of medicines.

- The systems for managing and storing medicines, including vaccines, medical gases, emergency medicines and equipment, generally minimised risks, except for hormone injection vials and controlled drugs recording at the branch surgery. Following inspection, the practice confirmed appropriate clinical waste boxes and an appropriate controlled drugs register were now in place.
- Although emergency medicines were kept in a non-patient area there was a potential risk of patient access to the area. Following inspection, the practice confirmed they had put in place tamper proof seals on the medicine boxes.
- Staff prescribed and administered or supplied medicines to patients and gave advice on medicines in line with current national guidance. The practice had reviewed its antibiotic prescribing and taken action to support good antimicrobial stewardship in line with local and national guidance. The practice was previously rated as the first out of 78 practices on the local clinical commissioning group table for appropriate antibiotic prescribing (practice 2.9% local 4.9 &, England average 8.7%) in 2017/18; they were currently the top performing practice for 2018/19.
- We saw the practice had extensive quality and safety workstream programs which included management protocols for medicine alerts, prescribing audits (which align to clinical commissioning group priorities) and audits arising from medicine issues within the practice. They used an analytical prescribing solution system to optimise medicine prescribing and increase cost effectiveness.
- Patients' health was monitored in relation to the use of medicines and followed up on appropriately. Patients were involved in regular reviews of their medicines.
- Arrangements for dispensing medicines at the practice kept patients safe.

Track record on safety

The practice had a good track record on safety.

- There were comprehensive risk assessments in relation to safety issues.
- The practice was signed up to the NHS England five 'sign up to safety' pledges.
- The practice monitored and reviewed safety using information from a range of sources. For example, within the GP federation all appropriate significant events were shared. The practice was able to demonstrate how they took action to prevent similar incidents.
- The practice had completed a Medical Protection Society clinical self-risk assessment to ensure they complied with national standards around quality of care and patient or staff safety. Action was taken to remedy the 49 identified risks such as ensuring all protocols were reviewed and stored electronically. Since completing the assessment, the practice had demonstrated 100% risk reduction in recognised risks. This demonstrated the practice took a proactive, whole-team approach to identifying risks before a potential significant event occurred and determine what action needed to be taken to reduce likelihood of an adverse outcome and to promote a safer culture.

Lessons learned and improvements made

The practice learned and made improvements when things went wrong.

- Staff understood their duty to raise concerns and report incidents and near misses. Leaders and managers supported them when they did so.
- There was a comprehensive incident policy which a detailed, robust process for reporting and was in line with legislation and guidance such as duty of candour. The policy was subject to regular reviews.
- The practice learned and shared lessons, identified themes and took action to improve safety in the practice. They used a root cause analysis approach to review and investigating when things went wrong. Monthly meetings were held to discuss all open incidents and significant events and to review two completed events to ensure post-implementation actions maximised safety. We saw thorough documentation and analysis of events.
- They underwent action learning sets with other practices which allowed them to implement changes to minimise harm.
- The practice acted on and learned from external safety events as well as patient and medicine safety alerts.

Good

Are services safe?

- They used 'learning from excellence' to review positive incidents. For example, they had a suspected measles case and undertook a learning from excellence investigation to ensure lessons learnt from a previous measles outbreak had been implemented effectively and had minimised risk which it had.
- The practice nurses undertook peer reviews for long term condition management. These were discussed in team meetings leading to a more consistent approach to care delivery and better patient outcomes. A synopsis and actions were documented.

Please refer to the evidence tables for further information.

Good

Are services effective?

We rated the practice and the population groups as good for providing effective services overall.

Effective needs assessment, care and treatment

The practice had systems to keep clinicians up to date with current evidence-based practice. We saw that clinicians assessed needs and delivered care and treatment in line with current legislation, standards and guidance supported by clear clinical pathways and protocols.

- Patients' immediate and ongoing needs were fully assessed. This included their clinical needs and their mental and physical wellbeing.
- We saw no evidence of discrimination when making care and treatment decisions.
- The practice used tele dermatology (electronically sending images to the hospital dermatology department) for simple and rapid access. This improved access to specialist triage and advice and in most cases allowed GPs to follow a suitable management plan suggested by a specialist.
- Staff advised patients what to do if their condition got worse and where to seek further help and support.
- The practice is in the process of "going for gold accreditation" for the Gold Standards Framework (GSF) implementation. The GSF is a quality improvement programme which is influential in end-of-life care (EOLC). We saw the practice demonstrated enhanced EOLC including earlier identification of patients and more advance care planning discussions which led to provision of high quality care and improved patient choice.
- GPs contacted patients after discharge from hospital, to reconcile medicine changes and to explore holistically the experience and concerns of both patient and carer. All discharge summaries were reviewed by dispensing staff and a GP, so medication changes were not missed.
- The Living Better Nurse project was developed by the practice to provide early intervention and prevention by effectively linking health and social care within the practice area; a collaborative approach to address needs of people with long term conditions through personalised care and support. Evidence gathered in 2016 demonstrated the practice had a 23% reduction in admissions; a reduction in GP appointments and reduced GP home visits by approximately a third.

Older people:

- Older patients who are frail or may be vulnerable received a full assessment of their physical, mental and social needs. The practice used an appropriate tool to identify patients aged 65 and over who were living with moderate or severe frailty. Those identified as being frail had a clinical review including a review of medication.
- The GPs contacted older patients discharged from hospital. This approach ensured that their care plans and prescriptions were updated to reflect any extra or changed needs.
- Staff had appropriate knowledge of treating older people including their psychological, mental and communication needs. Patients were referred to the living better nurse and social prescribing services to support them and prevent social isolation.

People with long-term conditions:

- Patients with long-term conditions had a structured annual review to check their health and medicines needs were being met. For patients with the most complex needs, the GP worked with other health and care professionals to deliver a coordinated package of care.
- Staff who were responsible for reviews of patients with long term conditions had received specific training.
- GPs followed up patients who had received treatment in hospital or through out of hours services for an acute exacerbation of asthma.
- Adults with newly diagnosed cardiovascular disease were offered statins for secondary prevention. People with suspected hypertension were offered ambulatory blood pressure monitoring and patients with atrial fibrillation were assessed for stroke risk and treated as appropriate.
- The practice was able to demonstrate how it identified patients with commonly undiagnosed conditions, for example, diabetes, chronic obstructive pulmonary disease (COPD), atrial fibrillation and hypertension.
- The practice's performance on quality indicators for long term conditions was comparable with national averages.
- Patients had access to wearable technologies that monitor levels of exercise, apps which allow users to access health coaches and online peer support groups. These encouraged self-care and management as well as the ability for patients to monitor their behaviour's.
- Patients at risk of diabetes were identified. And signed up to a NICE-aligned, accredited structured education

and behavioural change programme. (NHS Healthier You Diabetes Prevention Programme provided tailored, high-frequency 1 to 1 coaching and support from a diabetes specialist dietitian to promote behaviour change, with a focus on improving confidence in self-management and reducing the risk of complications of diabetes).

- Patients at risk of diabetes where seen by the practice nurse and offered an in-house support and information appointment and routine follow-up appointments.
- The associate practitioner and health care assistant used medically certified technology to screen patients opportunistically for atrial fibrillation (a common heart rhythm disorder) that increases the risk of stroke). A minimum of 50 patients had been screened per week since April 2018. By identifying the condition early patients can be treated and risk of a stroke reduced.
- One GP had undertaken work to ensure monitoring for medicines such as blood tests were undertaken in line with local recommendations. Staff referred to an accredited list when taking bloods during monitoring either as part of long term condition reviews or drug monitoring per se.
- The living better nurse supported patients to better self-manage and aimed to reduce their dependency on health and social care. They worked with patients on a personalised care plan and undertook medicine reviews.

Families, children and young people:

- Childhood immunisation uptake rates were above the NHS target percentage of 90% or above and the World Health Organisation target of 95%.
- The practice had arrangements for following up failed attendance of children's appointments following an appointment in secondary care or for immunisation. This was documented within patient records. The practice nurses have written to all patients that at the time of their MMR immunisation, NHS England recommended one immunisation. They have invited all these patients to return for a booster to improve protection against measles and rubella.

Working age people (including those recently retired and students):

- The practice's uptake for cervical screening was 77% (2016/17), which was below the 80% coverage target for the national screening programme. We looked at data to date for 2018/19 and saw the practice had carried out screening on 83% of the eligible practice list.
- The practice's uptake for breast and bowel cancer screening was above the national average. All patients who do not respond to invites for bowel cancer screening received a letter from their named GP discussing the importance of the test and encouraging uptake.
- The practice had systems to inform eligible patients to have the meningitis vaccine, for example before attending university for the first time.
- Patients had access to appropriate health assessments and checks including NHS checks for patients aged 40-74. There was appropriate follow-up on the outcome of health assessments and checks where abnormalities or risk factors were identified.

People whose circumstances make them vulnerable:

- End of life care was delivered in a coordinated way using the Gold Standards Framework (GSF) which considered the needs of those whose circumstances may make them vulnerable. We saw the practice could provide evidence of an improved approach such as advanced care plans for these patients and tools to assess clinical and holistic needs.
- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- The practice had a system for vaccinating patients with an underlying medical condition according to the recommended schedule.

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

- The practice assessed and monitored the physical health of people with mental illness, severe mental illness, and personality disorder by providing access to health checks, interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. There was a system for following up patients who failed to attend for administration of long term medication.
- When patients were assessed to be at risk of suicide or self-harm the practice had arrangements in place to help them to remain safe. Following recent patient

suicides, the practice had undertaken significant event analysis. As an outcome a training session for clinician's support had taken place. They had implemented a document of support signposting for a bereavement due to suicide, road traffic collision and specifically for men.

- Patients at risk of dementia were identified and offered an assessment to detect possible signs of dementia. When dementia was suspected there was an appropriate referral for diagnosis. The practice had adopted the clinical commissioning groups new dementia pathway which included a process for GPs to diagnose dementia in older patients who may not wish to go through the process of diagnosis and tests via the memory service. As a consequence, patients received an earlier diagnosis and referral to the living better nurse (LBN) to ensure they received the right support.
- The LBN undertook home visits and reviews to improve social isolation, support carers and help implement an individualised plan of care.
- The practice offered annual health checks to patients with a learning disability and their carers. These patients had care plans in place.
- We reviewed six records of patients who were experiencing mental health issues including patients with a learning disability. We saw individualised care and mental capacity was recorded in detail in patient records and referral letters.
- The GP trainee was section 12 mental health trained and was due to start a salaried post at the practice. One partner trained in psychiatry before general practice and a salaried GP was undertaking a MRCPsych (a postnominal qualification awarded to doctors who have completed additional training and examination mandated by the Royal College of Psychiatrists). This demonstrated the GPs had developed skills and knowledge in managing the complexities of care and treatment for patients experiencing poor mental health giving these patients a specialist service without reduced delays in secondary care referrals.

Monitoring care and treatment

The practice had a comprehensive programme of quality improvement activity and routinely reviewed the effectiveness and appropriateness of the care provided. Where appropriate, clinicians took part in local and national improvement initiatives.

The practice had opted out of fully using the national Quality and Outcomes Framework (QOF). (QOF is a system intended to improve the quality of general practice and reward good practice).

Where the practice did not use the QOF as a measure to check that specific areas of care and support were achieved with patients they had a programme of priority quality improvement areas which had identified as part of their participation in Somerset Practice Quality Scheme (SPQS). These were for 2018/2019:

- Improved diabetic care; Dementia; Bone health; Patients over the age of 65 risk of falls; Increase the number of patients attending for an annual review of hypertension; Increase the number of patients with a learning disability attending for an annual review.

The practice prioritised quality and safety by bringing together the strands involved in clinical quality improvement and safety under one work stream where programs of work were generated and discussed at clinical meetings.

We saw clinical audits aligned to practice priorities, health alerts, prescribing audits (which align to clinical commissioning group priorities), audits arising from issues with the practice such as significant events and complaints, audits required in the context of training programmes, and subjects generated from national audits (Cancer and Diabetes), medicolegal alerts and web based platforms which identify patients in whom there are potential risks due to the prescription of certain medicines. By systemically reviewing care provided and current practice through clinical audit, modifying it where necessary and then evaluating changes we saw improvements in the effectiveness and quality of patient care and outcomes.

- GPs had a variety of medical searches they undertook and shared for safety-netting purposes. For example, one GP had responsibility to undertake regular searches for female patients with breast cancer (which represented 2% of the practice population). This enabled them to update registers and ensure patients received appropriate care and treatment including psychological support and early contact from the practice.

Good

Are services effective?

- The practice had set up a 'admin task screen' within the patient record system to record soft information, messages relating to patients attending for appointment and tasks around following up test results, recalling for follow-up tests or non-attendance.
- The practice demonstrated that clinical audit was an integral part of the clinical work. For example, they had undertaken an after-death audit to review the quality of end of life care provided and improve outcomes for more patients. As a result, they introduced a form for the palliative monthly clinical meetings to check off each aspect of care which may be required for each patient on the list.
- In addition, they used a data quality indicator tool to benchmark, plan and develop strategies to improve quality of care. The tool enabled them to summarise elements of care for certain long-term conditions and at clinical meetings discuss how to implement changes to improve performance implemented.

Effective staffing

Staff had the skills, knowledge and experience to carry out their roles.

- Staff had appropriate knowledge for their role, for example, to carry out reviews for people with long term conditions, older people and people requiring contraceptive reviews.
- Staff whose role included immunisation and taking samples for the cervical screening programme had received specific training and could demonstrate how they stayed up to date.
- The practice understood the learning needs of staff and provided protected time and training to meet them. Locum GPs were involved in training sessions.
- Up to date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. For example, funding and support was provided to enable the health care assistant to undertake associate practitioner training.
- The practice provided staff with ongoing support. There was an induction programme for new staff. This included one to one meetings, appraisals, coaching and mentoring, clinical supervision and revalidation.
- There was a clear approach for supporting and managing staff when their performance was poor or variable.
- The practice nurses held weekly peer review sessions to review patient care and treatment, these were documented and learning outcomes recorded. GPs provided monthly educational sessions and peer support to the clinical team. For example, the nurse practitioner had weekly peer reviews with a GP partner. Clinical meetings also allowed protected time for learning.
- Dispensary staff were appropriately qualified and their competence was assessed regularly. They could demonstrate how they kept up to date.

Coordinating care and treatment

Staff worked together and with other health and social care professionals to deliver effective care and treatment.

- We saw records that showed that all appropriate staff, including those in different teams and organisations, were involved in assessing, planning and delivering individualised care and treatment. Multi-disciplinary team meetings had evolved from the living better nurse service and included older people mental health teams. There was a focus on identifying issues of health or social need, which impacted on patient's independence. Sharing of patient information promoted streamlined individual care and treatment plans.
- The practice shared clear and accurate information with relevant professionals when discussing care delivery for people with long term conditions and when coordinating healthcare for care home residents. They shared information with, and liaised, with community services, social services, voluntary and charitable organisations and carers for housebound patients and with health visitors and community services for children who have relocated into the local area.
- Patients received coordinated and person-centred care. This included when they moved between services, when they were referred, or after they were discharged from hospital. The practice worked with patients to develop personal care plans that were shared with relevant agencies.
- The practice had access to specialist advice such as cardiology and palliative care through a teleconference facility.
- Visiting specialist clinicians attended the practice for a range of areas including paediatrics, respiratory and

older persons. Educational sessions were held between the practice staff and the consultants to update staff and to allow for discussion of complex cases or case learning.
- The practice ensured that end of life care was delivered in a coordinated way which took into account the needs of different patients, including those who may be vulnerable because of their circumstances.

Helping patients to live healthier lives

Staff were consistent and proactive in helping patients to live healthier lives.

- The practice identified patients who may be in need of extra support and directed them to relevant services. This included patients in the last 12 months of their lives, patients at risk of developing a long-term condition and carers.
- Staff encouraged and supported patients to be involved in monitoring and managing their own health, for example through social prescribing schemes.
- Staff discussed changes to care or treatment with patients and their carers as necessary.
- The practice supported national priorities and initiatives to improve the population's health, for example, stop smoking campaigns, tackling obesity.
- The practice embraced social prescribing through their engagement with 'Moor to Enjoy', a national park funded health programme; the prescribing of books and referrals for therapeutic exercise.
- GPs wrote regular "Health Bites" article in the local village magazine, circulated to the whole village, with health promotion advice and updates on contemporary health issues.
- One GP worked with a local school to plan a health week and provide educational sessions.

Consent to care and treatment

The practice obtained consent to care and treatment in line with legislation and guidance.

- Clinicians understood the requirements of legislation and guidance when considering consent and decision making.
- Clinicians supported patients to make decisions. Where appropriate, they assessed and recorded a patient's mental capacity to make a decision.
- The practice monitored the process for seeking consent appropriately.
- We reviewed patient records and saw explicit and in-depth recording around mental capacity assessments and capacity decisions. The records had been appropriately coded.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services caring?

We rated the practice as outstanding for caring because

- **there was a strong, visible person-centred culture where staff were motivated and inspired to offer care that was kind, promoted people's dignity, and respected the totality of people's needs. They worked in partnership with patients to develop services.**

Kindness, respect and compassion

Staff treated patients with kindness, respect and compassion.

- Feedback from patients was positive about the way staff treat people.
- Staff understood patients' personal, cultural, social and religious needs.
- The practice gave patients timely support and information.
- The practices GP patient survey results (2018) were above local and national averages for questions relating to kindness, respect and compassion.
- Legacy money was used to fund night sitters to help end of life 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. For example, GPs divided the practice population area and gave a phone number to patient's families during end of life care so they could receive a personal service which included home visits for extra support and comfort.
- Staff had received training in emotion coaching to enable them to have an empathetic problem-solving approach to patient interactions and allowed them to understand the perspective of the patient and their behaviour.
- The Practice Manager was a wellness coach and had cascaded this training to staff.
- They provided a medicine pick up service for patients in rural locations.

Involvement in decisions about care and treatment

Staff helped patients to be involved in decisions about care and treatment. They were aware of the Accessible Information Standard (a requirement to make sure that patients and their carers can access and understand the information that they are given.)

- Staff communicated with people in a way that they could understand, for example, communication aids and easy read materials were available. Patients told us staff were sensitive, encouraging and supportive to them and their families.
- Staff helped patients and their carers find further information and access community and advocacy services. They helped them ask questions about their care and treatment.
- The practice proactively identified carers and supported them. They had a carers champion who had been trained to undertake frailty and falls risk assessments.
- New patient registration packs included questions to ask patients if they had any communication or information needs.
- We saw GPs worked in an advocacy role during discussions with mental health secondary care services, and supported with hospital consultations to help provide better outcomes for these patients. This included specific letters to try to expediate more timely appointments for those who were in crisis This demonstrated GPs, by talking to other health professionals on behalf of patients ensured their views were heard and acknowledged and this assisted patients to develop the knowledge, skills and confidence to manage their own health, care and wellbeing.
- We saw extensive recording of decisions around mental capacity. For patients with a learning disability we saw patient needs including discussions around diagnosis were fully recorded in patient records.
- A GP partner undertook liaison and training with local schools to promote health education for young people and new parents.
- The practice has embraced the concept of living well through the living better nurse (personalised care planning, support to improve quality of life through reconnection to the community and integrating services to specifically bring care and treatment closer to home for patients), therapeutic storytelling (to inspire a greater sense of wellbeing) and sessions for mindful

Are services caring?

emotional coaching (supporting children and young people to understand their behaviour and different emotions, and how to handle them and be more resilient).

- The practice had introduced a wellbeing scale to identify improvement in patient's mental-wellbeing as part of the storytelling project evaluation and as a result of seven out of eight patients stated their personal wellbeing had improved. As a result of patient experience the practice have introduced it as part of the living better service with 15 places available.
- The practices GP patient survey results (2018) were above local and national averages for questions relating to involvement in decisions about care and treatment.

Privacy and dignity

The practice respected patients' privacy and dignity.

- When patients wanted to discuss sensitive issues, or appeared distressed reception staff offered them a private room to discuss their needs.
- Staff recognised the importance of people's dignity and respect. They challenged behaviour that fell short of this.

Please refer to the evidence tables for further information.

Good

Are services responsive to people's needs?

We rated the practice, and all of the population groups as good for providing responsive services.

Responding to and meeting people's needs

The practice organised and delivered services to meet patients' needs. It took account of patient needs and preferences.

- The practice understood the needs of its population and tailored services in response to those needs.
- Telephone GP consultations were available which supported patients who were unable to attend the practice during normal working hours.
- The facilities and premises were appropriate for the services delivered.
- The practice made reasonable adjustments when patients found it hard to access services. Flu clinics were taken out to local villages to enable improved access and were not limited to registered patients and included invitation to local organisations.
- The practice provided effective care coordination for patients who are more vulnerable or who have complex needs. They supported them to access services both within and outside the practice.
- Care and treatment for patients with multiple long-term conditions and patients approaching the end of life was coordinated with other services.
- Previously, the 'friends of' the practice had funded a project for a living better nurse (LBN), in partnership with local healthcare, social services and charities, to improve social networks and care provision for patients. Following its success, the local clinical commissioning group (CCG) now funded this service across the GP federation. (A GP federation is a group of practices working together within their local area). The practice was aware of the restrictions of the CCG funded LBN project. They were evolving the role using funding from the practice 'friends of' charities to increase the length of time the nurse spent delivering this work to enable further monitoring and development of the role.
- The practice provided dispensary services for people who needed additional support with their medicines, for example a delivery service to local collection points and large print labels. Patient requests for weekly or monthly blister packs were referred to a local pharmacy.

Older people:

- All patients had a named GP who supported them in whatever setting they lived, whether it was at home or in a care home or supported living scheme.
- The practice was responsive to the needs of older patients, and offered home visits and urgent appointments for those with enhanced needs. The GP and living better nurse also accommodated home visits for those who had difficulties getting to the practice due to limited local public transport availability.
- There was a medicines delivery service for housebound patients.
- The practice worked with the local consultant for care of older people and enabled clinics to be held in the practice, saving patients a 50-mile round trip. It also enabled GPs to discuss other patients and they benefitted from face to face specialist feedback/ education. (GPs can also email directly for swift advice).

People with long-term conditions:

- Patients with a long-term condition received an annual review to check their health and medicines needs were being appropriately met. Multiple conditions were reviewed at one appointment, and consultation times were flexible to meet each patient's specific needs.
- The practice held regular meetings with the local district nursing team to discuss and manage the needs of patients with complex medical issues.
- Patients had access locally to a respiratory specialist. And a respiratory specialist visited the practice to discuss such patients and provide education sessions for clinical staff.
- Pulmonary rehabilitation clinics were hosted at Porlock Medical Centre to enable patients to attend a suitable venue that reduced rural travel.

Families, children and young people:

- We found there were systems 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 accident and emergency (A&E) attendances. Records we looked at confirmed this.
- All parents or guardians calling with concerns about a child under the age of 18 were offered a same day appointment when necessary.
- The health visitor, due to the rural area, attended childhood immunisation clinics for families to access advice and support.

Good

Are services responsive to people's needs?

- One GP provided support to a local school for those children and their parents in need of extra emotional support.
- The practice participated in Somerset Emotion Coaching which supported children, young people and families with behavioural, emotional and mental health difficulties, many of whom had experienced significant adversity. The programme was run by their locum GP with a special interest (GPwSI) in neurodevelopment.
- Staff had also received an introduction to an evidence based parenting programme in emotion coaching 'Tuning into kids' for which the practice manager was trained in
- The practice had an information pack for 13-16-year olds to address relevant issues such as contraception and support.
- One GP was working towards a diploma in sexual and reproductive health to enable the practice to improve availability for intra-uterine coil fitting.
- The practice encouraged uptake of an online counselling and emotional well-being platform for children and young people.
- A visiting paediatrician was hosted by the practice. Local families avoided expensive travel and GPs could discuss other children with the consultant.
- The practice was a 'Positive about Breastfeeding' practice. (The scheme aims to facilitate greater acceptance and promotion of breastfeeding in commercial, health and community settings, with the overall goal of increasing the numbers of mothers who feel comfortable and confident to breastfeed their baby).

Working age people (including those recently retired and students):

- The needs of this population group had been identified and the practice had adjusted the services it offered to ensure these were accessible, flexible and offered continuity of care. For example, extended opening hours and Saturday appointments.
- Nursing staff offered a cryotherapy clinic to make this service more accessible to patients.

People whose circumstances make them vulnerable:

- The practice held a register of patients living in vulnerable circumstances including homeless people, travellers and those with a learning disability.
- People in vulnerable circumstances were easily able to register with the practice, including those with no fixed abode.
- The practice had 'about me' booklets (completed by patients and their carers) which crucial information such as access or communication needs. This ensured care and treatment for people with a learning disability was at an appropriate level. Patients and their carers were encouraged to complete these prior to an appointment. They used pictograms during appointments so patients could understand the information easily.
- All staff could highlight any concerns and add patients to a 'worry list' to discuss at the multidisciplinary meeting or sooner with GPs.
- All patients who failed to attend were added to the admin screen and contacted by clinical staff.
- The LBN helped patients develop advanced care plans, undertook frailty reviews/falls assessments and attended complex care multidisciplinary meetings. This allowed early intervention discussion and admissions avoidance. They supported patients to access services both within and outside the practice working alongside village agents who advise on social, financial and non-medical issues.

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

- Staff interviewed had a good understanding of how to support patients with mental health needs and those patients living with dementia.
- The practice held GP led mental health and dementia clinics. Patients who failed to attend were proactively followed up by a phone call from a GP.
- When patients with dementia were required to return for a follow-up appointment including blood tests or an x-ray they were added to the admin screen to ensure they were contacted and reminded to attend.
- One GP had undertaken Dementia Friends training and the practice was rolling out and encouraging all staff to become Dementia Friends.
- Porlock village was working towards a dementia friendly village status and one GP was acting as liaison for the project.
- The practice provided a comprehensive range of Alzheimer society booklets including easy read and braille formats.

Good

Are services responsive to people's needs?

- The practice was engaged in a local community day and had secured a local consultant to provide a talk on dementia.
- Talking therapies was available and the practice hosted counselling and hypnotherapy services.

Timely access to care and treatment

Patients were able to access care and treatment from the practice within an acceptable timescale for their needs.

- Patients had timely access to initial assessment, test results, diagnosis and treatment.
- Waiting times, delays and cancellations were minimal and managed appropriately.
- Patients with the most urgent needs had their care and treatment prioritised.
- Patients reported that the appointment system was easy to use.
- The practices GP patient survey results (2018) were above local and national averages and showed a significant positive variation for questions relating to access to care and treatment.

Listening and learning from concerns and complaints

The practice took complaints and concerns seriously and responded to them appropriately to improve the quality of care. The practice manager had undertaken a complaint handling course.

- Information about how to make a complaint or raise concerns was available. Staff treated patients who made complaints compassionately.
- The complaint policy and procedures were in line with recognised guidance. The practice learned lessons from individual concerns and complaints and from analysis of trends. It acted as a result to improve the quality of care.

Please refer to the evidence tables for further information.

Outstanding ☆

Are services well-led?

The practice was rated as outstanding for well-led because the leadership and culture was used to drive and improve the delivery of high-quality person-centred care.

There was compassionate, inclusive and effective leadership with an embedded system of progression and development which aimed to ensure that there was a whole team approach to service delivery.

Since our previous inspection a project developed and funded by the practice led to the service being commissioned by the CCG and rolled out to other local GP practices. The project integrated health and social care with voluntary and charitable organisations to support people with complex needs to better self-manage, improve their quality of life through reconnection to their community and reduce dependency on health and social care.

Leadership capacity and capability

Leaders had the capacity and skills to deliver high-quality, sustainable care.

- Leaders were knowledgeable about issues and priorities relating to the quality and future of services. They understood the challenges and were addressing them. For example, the practice has carried out two Score surveys to measure dimensions of organisational culture such as leadership, team culture, learning systems, resilience and work-life balance. After the initial survey an action plan was implemented to facilitate cross-team communication; improve leadership and management; increase staff learning; improve succession planning and merge the cultures from the different practices.
- Leaders at all levels demonstrated the high levels of experience, capacity and capability needed to deliver high quality, safe, sustainable care. They took responsibility and were accountable for their area of service provision. In addition, they took additional external roles. For example, the practice manager was a GP federation lead for quality improvement; one GP was director of clinical governance for a Somerset GP organisation which looks to ensure high quality NHS care is maintained and one GP was part of the nursing and patient safety forum for NHS England South West as well as performance and governance director.
- Leaders at all levels were visible and approachable. They worked closely with staff and others to make sure they prioritised compassionate and inclusive leadership. This included pastoral care for other health professionals and supporting GPs to return to practice.
- The practice had effective processes to develop leadership capacity and skills, including planning for the future leadership of the practice.

Vision and strategy

The practice had a clear vision and credible strategy to deliver high quality, sustainable care.

- There was a clear vision and set of values. The practice had a realistic strategy and supporting business plans to achieve priorities.
- Staff were aware of and understood the vision, values and strategy and their role in achieving them. They told us they worked together to make the vision a reality for patients.
- The strategy was in line with health and social care priorities across the region. The practice planned its services to meet the needs of the practice population.
- There was a systematic and integrated approach to monitoring, reviewing and providing evidence of progress against the strategy and plans. Plans were consistently implemented, and had a positive impact on quality and sustainability of services. The practice monitored progress against delivery of the strategy through regular meetings, feedback sessions and Score surveys.

Culture

The practice had a culture of high-quality sustainable care.

- Staff stated they felt respected, supported and valued. They were proud to work in the practice. There were high levels of satisfaction across all staff.
- The practice focused on the needs of patients. The Living Better Nurse (LBN) project was able to demonstrate collaborative working (health and social care and charitable organisations) and improved quality of life for patients with a long-term condition. Its success led to funding by the clinical commissioning group for all practices across the GP federation. The practice had recently asked 'the friends of' practice charity to release

more funding to enable them to evolve the service, keep patients at home for longer and continue with extra monitoring that the commissioned nurse service does not provide.
- Leaders and managers acted on behaviour and performance inconsistent with the vision and values.
- Openness, honesty and transparency were demonstrated when responding to incidents and complaints. The provider was aware of and had systems to ensure compliance with the requirements of the duty of candour. They could demonstrate this through documentation of discussions with patient's families following significant incidents.
- Staff we spoke with told us they could raise concerns and were encouraged to do so. They had confidence that these would be addressed.
- There was a strong focus on learning and development. They provided all staff with the development they need. This included appraisal and career development conversations. All staff received regular annual appraisals in the last year. We found evidence that appraisal was embedded for all staff and investment in staff development such as 360-degree feedback was a priority for the practice.
- There was a strong emphasis on the safety and well-being of all staff. For example, Free online or face to face counselling was made available and personal emotional coaching sessions were provided to staff. The practice manager had trained to be a wellness coach and was able to provide personal and work-based support and coaching to staff.
- The practice actively promoted equality and diversity. Staff had received equality and diversity training. Staff felt they were treated equally.
- There were positive relationships between staff and teams.

Governance arrangements

There were clear responsibilities, roles and systems of accountability to support good governance and management.

- Structures, processes and systems to support good governance and management were clearly set out, understood and effective. The governance and management of partnerships, joint working arrangements and shared services promoted co-ordinated person-centred care.
- Staff were clear on their roles and accountabilities including in respect of safeguarding and infection prevention and control.
- Practice leaders had established policies, procedures and activities such as a recognised practice-based clinical risk assessment to ensure safety, minimise future risks and assure themselves that they were operating as intended.

Managing risks, issues and performance

There were clear and effective processes for managing risks, issues and performance with a strong focus on quality and safety. Leaders had brought together the strands involved in clinical quality improvement and safety under one work stream which was regularly discussed at clinical meetings.

- There was an effective, process to identify, understand, monitor and address current and future risks including risks to patient safety. For example, Staff received training in clinical risk assessment and undertook a recognised clinical risk self-assessment of the practice with the aim of building a safer culture (following practice mergers) and providing improved care. The practice identified they had addressed the 49 identified risks.
- The practice had processes to manage current and future performance. Practice leaders had oversight of safety alerts, incidents, and complaints which was routinely shared with staff and the patient participation group.
- Clinical audit had a positive impact on quality of care and outcomes for patients. There was clear evidence of action to change practice to improve quality. Staff actively engaged with national programmes of audit such as the National Cancer Audit, the National Diabetes Audit and as part of the Royal College of General Practitioners (RCGP) sentinel practice scheme.
- The practice had plans in place and had trained staff for major incidents.
- The practice considered and understood the impact on the quality of care of service changes or developments.

Appropriate and accurate information

The practice acted on appropriate and accurate information.

Outstanding ☆

Are services well-led?

- Quality and operational information was used to ensure and improve performance. Performance information was combined with the views of patients.
- Quality and sustainability were discussed in relevant meetings where all staff had sufficient access to information.
- The practice used performance information which was reported and monitored and management and staff were held to account.
- The information used to monitor performance and the delivery of quality care was accurate and useful. There were plans to address any identified weaknesses.
- The practice used information technology systems to monitor and improve the quality of care.
- The practice submitted data or notifications to external organisations as required.
- There were robust arrangements in line with data security standards for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

Engagement with patients, the public, staff and external partners

The practice involved patients, the public, staff and external partners to support high-quality sustainable services.

- A full and diverse range of patients', staff and external partners' views and concerns were encouraged, heard and acted on to shape services and culture. For example, a locum GP suggested the practice had a duty doctor system. A pilot was introduced which led to three practice reviews and changes to the system.
- There was an active patient participation group and two 'friends of' charitable groups.
- The service was transparent, collaborative and open with stakeholders about performance.
- The GPs provided a mentor role for District Nurses undertaking an independent prescribers course.

Continuous improvement and innovation

There was evidence of systems and processes for learning, continuous improvement and innovation.

- There was a focus on continuous learning and improvement.
- Staff knew about improvement methods and had the skills to use them.
- The practice made use of internal and external reviews of incidents and complaints. Learning was shared and used to make improvements.
- Leaders and managers encouraged staff to take time out to review individual and team objectives, processes and performance.
- The practice had an emphasis on a safer culture and improved patient care through implementation of systems and processes throughout the whole team such as Score surveys, MPS clinical risk assessment, "going for gold accreditation" for the Gold Standards Framework (GSF) implementation, practice nurses undertake peer reviews and benchmarking for long term conditions and high quality clinical audit.

Please refer to the evidence tables for further information.