Cheddar Medical Centre

Quality Report

Roynon Way
Cheddar
Somerset
Tel: 01934 742061
Website: www.chedmed.nhs.uk

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

Ratings

Overall rating for this service	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

Contents

Overall summary

Letter from the Chief Inspector of General Practice

We carried out an announced comprehensive inspection at Cheddar Medical Practice on 2 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 rated as good for providing services for all of 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.
- 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.
- The practice used innovative and proactive methods to improve patient outcomes, working with other local providers to share best practice.
- The practice implemented suggestions for improvements and made changes to the way it delivered services as a consequence of feedback from patients and from the Patient Participation Group (PPG).
- The practice facilities were designed and equipped to meet patients' treatment needs.

Summary of findings

- Information about how to complain was available and easy to understand.

We saw areas of outstanding practice:

- The practice is part of the North Sedgemoor Federation of GP practices in Somerset who use the Somerset Village Agent project . The project uses paid, part time, highly trained individuals living in the parish 'clusters' they support. They help to bridge the gap between socially isolated, excluded, vulnerable and lonely individuals and statutory and/or voluntary organisations which offer specific solutions to identified needs. The North Sedgemoor Federation also funds the Singing for the Brain service for people living with dementia, which was initiated in 2014 and is funded until 2016, and provided by the Alzheimer's Society.
- We found one GP had been nominated as an "NHS hero" which is a new scheme to recognise the work that individuals and teams do every day in the NHS. They are the only GP in Somerset to have received this award.

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 report incidents and near misses. For example, we were shown the investigations and significant event analysis that had been carried out and the action taken. Staffing levels and skill mix was planned and reviewed so that patients received safe care and treatment at all times. The arrangements in place to safeguard adults and children from abuse reflected relevant legislation and local requirements. The practice had arrangements in place to respond to emergencies and other unforeseen situations such as the loss of utilities.

Are services effective?

Good

The practice is rated as good for providing effective services. Our findings at inspection showed systems were in place to ensure that all clinicians were up to date with both National Institute for Health and Care Excellence guidelines and other locally agreed guidelines. We also saw evidence to confirm that these guidelines were positively influencing and improving practice and outcomes for patients. Information about the outcomes of patients' care and treatment was routinely collected and monitored through auditing and data collection. For example, the practice undertook clinical audits identify appropriate use of blood monitoring of a prescribed treatment. We found staff had the skills, knowledge and experience to deliver care and treatment and had undertaken additional training to support this.

Are services caring?

Good

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

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services. The practice had initiated positive service improvements for its patients. It acted on suggestions for improvements and changed the way it delivered services in response to feedback from the patient

Summary of findings

participation group (PPG). It reviewed the needs of its local population and engaged with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified. We found urgent and routine appointments were available the same day. Information about how to complain was available and easy to understand and evidence showed that the practice responded quickly to issues raised.

Are services well-led?

Good

The practice is rated as good for being well-led. The practice is rated as good for being well-led. It had a clear vision and strategy. Staff were clear about the vision and their responsibilities in relation to this. There was a clear leadership structure and staff felt supported by management. The practice had a number of policies and procedures to govern activity. There were systems in place to monitor and improve quality and identify risk. The practice proactively sought feedback from staff and patients, which it acted on. The patient participation group (PPG) was very 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 people. Nationally reported data showed that outcomes for patients were good for conditions commonly found in older people. The practice offered proactive, personalised care to meet the needs of the older people in its population and had a range of enhanced services, for example, emergency admission avoidance. Patients over 75 had a named GP. We found integrated working arrangements with community teams. The practice worked closely with carers and one staff member acted as the carer's champion.

People with long term conditions

Good

The practice is rated as good for the care of people with long-term conditions. Nursing staff had lead roles in chronic disease management. Patients diagnosed with long term conditions were supported through a range of clinics held for specific conditions such as, asthma, chronic obstructive pulmonary disease (COPD) and heart failure. Weekly nurse led clinics were available to patients diagnosed with long term conditions. Longer appointments and home visits were available when needed. All of these patients had a structured annual review to check their health and medicines needs were being met. Patients receiving palliative care, those with cancer diagnosis and patients likely to require unplanned admissions to hospital were added to the Out of Hours system to share information and patient choices and decisions with other service providers.

Families, children and young people

Good

The practice is rated as good for the care of families, children and young people. There were systems in place to identify and follow up children living in disadvantaged circumstances and who were at risk, for example, children and young people who had a high number of A&E attendances. Immunisation rates were relatively high for all standard childhood immunisations. Appointments were available outside of school hours and the premises were suitable for children and babies. There was joint working with midwives, health visitors and school nurses. The practice worked to provide inclusive services for younger patients, such as having the community adolescent mental health services hold sessions there and actively engaged with local schools.

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Working age people (including those recently retired and students)

Good

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

People whose circumstances may make them vulnerable

Good

The practice is rated as good for the care of people whose circumstances may make them vulnerable. They held a register of vulnerable patients such as those with a learning disability. The practice provided support to four local care homes for patients with learning disabilities and four members of their staff are members of Patient Participation Group. The practice had a lead GP to support these patients and provide continuity of care. We saw the waiting room had an area where easy read material was available which explained about GP appointments. The practice regularly worked with multi-disciplinary teams in the case management of vulnerable patients. Staff knew how to recognise signs of abuse in vulnerable adults and children. Staff were aware of their responsibilities regarding safeguarding concerns and how to contact relevant agencies in normal working hours and out of hours.

People experiencing poor mental health (including people with dementia)

Good

The practice is rated as good for the care of people experiencing poor mental health (including people with dementia). The practice regularly worked with multi-disciplinary teams in the case management of people experiencing poor mental health, including those with dementia. The practice is part of the North Sedgemoor Federation which funds 'Singing for the Brain' sessions. Patients could access mental health support services at the practice. The practice had told patients experiencing poor mental health about how to access various support groups and voluntary organisations such as talking therapies.

Summary of findings

What people who use the service say

We spoke with patients visiting the practice and we received 11 comment cards from patients who visited the practice. We also looked at the practices NHS Choices website to look at comments made by patients. (NHS Choices is a website which provides information about NHS services and allows patients to make comments about the services they received). We also looked at data provided in the most recent NHS GP patient survey.

The patient survey data showed:

- 94% of respondents found it easy to get through to the practice by phone
- 88% of respondents found the receptionists at this practice helpful
- 75% of respondents with a preferred GP usually get to see or speak to that GP
- 89% of respondents were able to get an appointment to see or speak to someone the last time they tried
- 97% of respondents said the last appointment they got was convenient
- 86% of respondents described their experience of making an appointment as good
- 72% of respondents usually waited 15 minutes or less after their appointment time to be seen

These results are equal to or better than the average for Somerset Clinical Commissioning Group.

We read the commentary responses from patients and noted they included observations such as

- Appointments are easy to make
- Good continuity of service
- Staff are considerate and kind
- We are treated with dignity and respect
- Excellent service
- Good relationships with all staff

We also spoke to approximately 15 patients when we attended a social morning organised by the patient participation group. Patients who expressed an opinion or comment confirmed those on the written comment cards. The comments made by patients were very positive and praised the care and treatment they received. For example, patients had commented about being involved in the care and treatment provided, and feeling confident in their treatment.

The practice had a patient participation group (PPG) and a virtual patient representation group (PRG) of approximately 125 patients. The gender and ethnicity of group was representative of the total practice patient population. Information about the group was available on the website. We spoke with patients who had been involved with the patient consultation groups who told us they worked with the practice for service improvement. For example, the PPG had identified a lack of information about other health care services in the local area as a priority. The action taken by the practice included:

- Publication by the practice and PPG of a leaflet which explains the local transport services and how to access them.
- The practice PPG notice board having a 'signpost to Local Support' section which listed the local support network, contact details and a description of the services and support provided.
- The PPG and the practice worked together to reorganise the display of leaflets in the practice so information could be easily found and/or obtained as necessary.

This highlighted support areas which were lacking in the local area, which in turn has led to a project to encourage a number of patients becoming 'patient champions' to act as signposts to support with patients suffering from similar conditions, e.g. Parkinson's, Fitness for the Over Fifties.

The impact for patients was that they had access to information of local support and contact with patient champions for dedicated conditions.

The practice had made an effort to extend PPG membership by initiating the following:

- First school – a practice poster competition which was displayed in the waiting room
- Contact with the Sixth form college to request a sixth form community representative

Summary of findings

- Attending the mother and toddler group at the children's centre and providing health promotion information.

The general practice population had information about the PPG through newsletters, information leaflets, local Cheddar papers, practice notice board, a Facebook page, and parish council meetings and raised at local MyCheddar meetings of the Cheddar community.

The practice had also commenced their current 'friends and family' survey which was available in a paper format, online and through use of an iPad placed in the reception area.

Outstanding practice

- The practice is part of the North Sedgemoor Federation of GP practices in Somerset who use the Somerset Village Agent project . The project uses paid, part time, highly trained individuals living in the parish 'clusters' they support. They help to bridge the gap between socially isolated, excluded, vulnerable and lonely individuals and statutory and/or voluntary organisations which offer specific solutions to identified needs. The North Sedgemoor Federation funds the local Singing for the Brain service for people living with dementia, which was initiated in 2014 and is funded until 2016, and is provided by the Alzheimer's Society.
- We found one GP had been nominated as an "NHS hero" which is a new scheme to recognise the work that individuals and teams do every day in the NHS. They are the only GP in Somerset to have received this award.

Cheddar Medical Centre

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC Lead Inspector. The team included a GP and a nurse specialist advisor.

Background to Cheddar Medical Centre

Cheddar Medical Practice is located in a rural area of Somerset. They have approximately 7500 patients registered the majority of whom are of a White British ethnicity.

The practice operates from one location:

Cheddar Medical Practice

Roynon Way

Cheddar

BS27 3NZ

It is sited in a purpose built two storey building which it shares with community based health care staff. The consulting and treatment rooms for the practice are situated on the ground floor. There is limited patient parking immediately outside of the practice with spaces reserved for those with disabilities.

The practice is made up of five GP partners working alongside qualified nurses and health care assistants. The practice has a general medical service contract and also has some additional enhanced services such as unplanned admission avoidance. The practice is open on Monday to Friday 8.30am – 6pm for on the day urgent and pre-booked routine GP and nurse appointments. There is a duty doctor available for emergencies only from 8am- 6.30pm.

The practice is a training practice for doctors who were training to be qualified as GPs. Patients seen by these GPs are given longer appointments and the trainee has access to a senior GP throughout the day for support.

The practice does not provide out of hour's services to its patients, this is provided by Somerset Doctors Urgent Care with effect from 1/7/15. Contact information for this service is available in the practice and on the website.

Patient Age Distribution

0-4 years old: 4.7%

5-14 years old: 11.1%

Under 18 years: 14.6%

65-74 years old: 24.5% - higher than the national England average.

75-84 years old: 11.5% - higher than the national England average.

85+ years old: 3.6% - higher than the national England average.

Information from NHS England indicates the practice is in an area of low deprivation with a lower than national average number of patients with long standing health conditions, a higher than average number of patients in nursing homes and high levels of employment. The patient gender distribution was male 48.8% and female 51.2%.

Detailed findings

Why we carried out this inspection

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

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

How we carried out this inspection

Before visiting, we reviewed a range of information that we hold about the practice and asked other organisations to share what they knew. We carried out an announced visit on 2 June 2015 . During our visit we spoke with a range of staff including GPs, nurses, community nurse based at the site, reception and administrative staff and the management team, and spoke with patients who used the service. We observed how patients were being cared for and talked with carers and/or family members and reviewed anonymised treatment records of patients.

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

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

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

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

People experiencing poor mental health (including people with dementia)

Good

Are services safe?

Our findings

Safe track record.

The practice had robust systems in place for the safety of patients and staff who worked at the service. For example, we saw that the health and safety issues for the practice were delegated to an external company who ensured safety audits were carried out and reported to the practice manager. The practice ensured that all staff were trained to a level of competence which kept patients safe. We saw records of training which indicated staff had been updated to understand and implement the latest guidance for treatment such as how to deal with anaphylaxis.

We spoke with four GPs, and reviewed information about both clinical and other incidents that had occurred at the practice. We were given information about nine incidents which had occurred during the last 12 months. These had been reviewed under the practices significant events analysis process. We read each event was categorised and all were reviewed for any trends; where changes in practice had been highlighted we were able to confirm they had been implemented. When events needed to be raised externally, such as with other providers or other relevant bodies, this was done and appropriate steps were taken, such as providing information to NHS England in response to a complaint. National patient safety alerts and other safety guidance was checked and circulated to the relevant staff.

The practice manager told us how comments and complaints received from patients were responded to. Staff we spoke with were aware of their responsibilities to raise concerns, and how to report incidents or events. We read minutes of meetings which evidenced that the above information was recorded and reviewed by the partners at the practice to prevent recurrence.

Learning and improvement from safety incidents.

All incidents were recorded as significant events format and appropriate action taken to improve systems and processes so that further incidents were prevented. For example, the practice had a system in place for reporting, recording and monitoring significant events. The records we reviewed showed that each clinical event or incident was analysed and discussed by the GPs, nursing staff and senior practice management. When we spoke with other staff we were told that the findings from these Significant Events Analysis (SEA) processes were disseminated to other practice staff if relevant to their role. We found the level and quality of incident reporting showed the level of harm and near misses, which ensured a robust picture of safety. The practice had also contributed to the South West cancer network library with a SEA relating to cancer diagnosis. We found the GPs maintained detailed records of the SEA's and the practice manager produced a summary for an annual review.

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

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

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

Reliable safety systems and processes including safeguarding

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

Good

Are services safe?

There are comprehensive systems to keep patients safe, which took account of current best practice. Staff knew how to recognise signs of abuse in older patients, vulnerable adults and children. They were also aware of their responsibilities. Staff knew how to share information, record information about safeguarding concerns and how to contact the relevant agencies in working hours and out of normal hours. Contact details were easily accessible. All staff we spoke to were aware of who the leads were for safeguarding adults and children and who to speak to in the practice if they had a safeguarding concern.

A proactive approach to anticipating and managing risks to patients was embedded and was recognised as the responsibility of all staff. There was a system to highlight vulnerable patients on the practice's electronic records. Staff were alerted with 'pop ups' when patients records were accessed. This included information to make staff aware of any relevant issues when patients attended appointments for example, children who were subject to child protection plans. We saw the practice produced a list each month of vulnerable children and ensured they were correctly recorded on the electronic record system and records updated.

The lead safeguarding GP was aware of the patients who had been assessed as vulnerable children and adults. Information from the GPs demonstrated good liaison with partner agencies such as the police and social services and they participated in multi-agency working. Regular discussions took place with health visitors in regard to children identified as at risk.

There was a chaperone policy, which was visible in the waiting room and in consulting rooms. There was a chaperone protocol for staff which set out clear steps staff should take and how chaperone support should be recorded in patient's records. The nurses were the only staff who acted as chaperones. Patients told us they were aware of the availability of chaperones if they required it.

Medicines management

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures, with daily checks, and which described the action to take in the event of a potential failure. The practice staff followed the policy.

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

The practice had a GP who was the prescribing lead and they were able to describe the processes in place for reviewing prescribing at the practice. This was supported by a pharmacist funded by the clinical commissioning group. We saw records which noted the actions taken in response to a review of prescribing data. For example, patterns of prescribing of quinolone, cephalosporin and co-amoxiclav are being reviewed to ensure good practice was followed. The practice had agreed actions which impacted on patient care such as liaising with the local laboratories about sensitivity results so most effective medicines are prescribed.

The nurses administered vaccines using directions that had been produced in line with legal requirements and national guidance. We saw up-to-date copies of patient group directives and evidence that nurses had received appropriate training to administer vaccines. There was a system in place for the management of high risk medicines, which included regular monitoring that followed the national guidance. We found appropriate action was taken based on the results.

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

Cleanliness and infection control

Good

Are services safe?

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.

The practice had a nurse with lead responsibility for infection control who had undertaken further training to enable them to provide advice on the practice infection control policy and carry out staff training. All staff received induction training about infection control specific to their role and received annual updates. We saw evidence that the practice had carried out audits and any improvements identified for action were completed on time. For example, cleaning all non-disposable privacy curtains.

An infection control policy and supporting procedures were available for staff to refer to, which enabled them to plan and implement measures to control infection. For example, the storage and use of personal protective equipment including disposable gloves, aprons and coverings. We also saw records were kept of staff training and updates, and immunisation status. The policies and protocols were available for staff to use and staff were able to describe how they would use these to comply with the practice's infection control guidance. For example, when carrying out intimate patient examinations or taking blood samples. There was also a policy for needle stick injury and staff we spoke with knew the procedure to follow in the event of an injury.

Notices about hand hygiene techniques were displayed in staff and patient toilets. Hand washing sinks with wall mounted hand soap, hand gel and hand towel dispensers were available in treatment rooms. Taps were elbow operated and work surfaces had sealed and rolled edges to reduce the risk of cross infection accumulating. Waste bins were foot operated in clinical area to maintain hygiene standards.

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

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

Equipment

The practice was suitably designed and adequately equipped. The building, its fixtures and fittings were owned jointly by one of the current partners and two retired partners. The practice had a clear leasehold agreement which identified who was responsible what which areas; the practice manager employed specialist contractors as needed. Staff we spoke with told us they had equipment to enable them to carry out diagnostic examinations, assessments and treatments. They told us that all equipment was tested and maintained regularly and we saw equipment maintenance logs and other records such as certificates that confirmed this.

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

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

There was a range of appropriate seating in the waiting areas such as lower chairs for children and chairs with arms to aid less mobile patients to stand; all appeared in safe condition. Adjustable examination couches were available in all treatment rooms which had appropriate privacy screening.

Staffing and recruitment

We were able to see 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 criminal records checks through the Disclosure and Barring Service (DBS). The practice had a recruitment policy that set out the standards it followed when recruiting clinical and non-clinical staff. We looked at three employee files for the most recent recruits and confirmed this had been implemented. When looking at the staff files we saw there was an induction checklist appropriate to the role of the staff member. Staff we spoke confirmed these had been used.

Good

Are services safe?

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

Staff told us there were usually enough staff to maintain the smooth running of the practice and there were always enough staff on duty to keep patients safe. This was reflected in the comments made by patients about the staff at the practice. We were told by the reception supervisor how they managed rotas so that the skill mix met with planned staffing requirements. For example, where necessary regular locum staff were employed who could demonstrate they had the suitable skills and experience to provide a continuity of care for patients.

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 annual and monthly checks of the building, the environment, medicines management, staffing, dealing with emergencies and equipment. The practice also had a health and safety policy. Health and safety information was displayed for staff to see and there was an identified health and safety representative. Cleaning materials were stored in way which met the Control of Substances Hazardous to Health (CoSHH) guidelines.

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

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw there was first aid equipment available on site and first aiders available when the practice was open. We looked at the accident recording log book and found when accidents had occurred at the practice, they were recorded and appropriate action taken to prevent recurrence. No accidents had been recorded since 2010.

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

Emergency medicines were also available in a secure area of the practice and were routinely audited to ensure all items were in date and fit for use. All staff had completed basic life support training and knew where emergency medicines and equipment were stored and how to use it, for example, for the treatment of cardiac arrest, anaphylaxis and hypoglycaemia. The practice had developed a practice specific protocol for dealing with emergencies such as cardiac arrest following an incident. 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.

Emergency equipment available included oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). The equipment appeared to be in good working order and designated staff members routinely checked this equipment. Equipment was available in a range of sizes for adults and children.

Urgent appointments were available each day both within the practice and for home visits. We were told that the practice prioritised requests for urgent appointments for children. Out of Hours emergency information was provided in the practice, on the practice's website and through their telephone system. The patients we spoke with told us they were able to access emergency treatment if it was required and had never been refused access to a GP.

The practice had an alarm system within the computerised patient record system to summon help if needed. A business continuity plan was in place to deal with a range

Good

Are services safe?

of emergencies that may impact on the daily operation of the practice. Each risk was rated and mitigating actions recorded to reduce and manage the risk. Risks identified included power failure, adverse weather, unplanned sickness and access to the building. The document also contained relevant contact details for staff to refer to and who was responsible for what needed to be carried out. For example, contact details of the power supplier.

The building had a fire system and firefighting equipment, which was in accordance with the fire safety legislation. A fire risk assessment had been undertaken in 2014 which included actions required to maintain fire safety. We saw records that showed the system had been maintained and tested. Records showed that staff were up to date with fire training and that they practised regular fire drills.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

The GPs and nursing staff we spoke with told us about their approaches to providing care, treatment and support to their patients. They were familiar with current best practice guidance, and accessed guidelines from the National Institute for Health and Care Excellence (NICE) and from local commissioners. New guidelines were disseminated to staff by the practice manager and the implications for the practice's performance and patients were discussed and required actions agreed. The staff we spoke with and the evidence we reviewed confirmed that these actions were designed to ensure that each patient received support to achieve the best health outcome for them. We found from our discussions with the GPs and nurses that staff completed thorough assessments of patients' needs in line with NICE guidelines, and these were reviewed when appropriate.

The practice used a risk stratification tool aligned with professional knowledge of patients to identify high risk patients and it participated in joint working with other health and social care professionals and services to avoid any crisis in their health. All patients over 75 had a named GP. The practice used computerised tools to identify patients with complex needs who had multidisciplinary care plans documented in their case notes. We were shown the process the practice used to review patients care plans. We saw that the practice provided the emergency admission avoidance enhanced service. This meant patients in this category who were recently discharged from hospital were reviewed within 72 hours. This was monitored by the staff on receipt of discharge summaries, who ensured they were followed up by the most appropriate staff member.

The patients we spoke with told us there was a holistic approach to assessing, planning and delivering care and treatment and we were given examples of how GPs and nurses involved them in their care and treatment. For example, patients told us they were always given treatment options and were supported to make a decision on what would be most appropriate treatment for them.

The GPs told us they had lead responsibility for specialist clinical areas and internal referral between clinicians took place for a variety of conditions such as diabetes and heart disease. The practice nurses supported this work and held specialist training qualifications in order to hold nurse led clinics. One GP acted as the clinical lead for the nurse team. Clinical protocols were in place and had been adapted by the practice to add value to patient care. The GP clinical lead for asthma, COPD and chronic kidney disease met with the nurses to assess what they had included in their annual review. New guidelines were produced for the clinical team to follow which included the main points from the NICE guidance. This information was added to the practice intranet for easy access.

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

Management, monitoring and improving outcomes for people

We spoke with GPs about how they reviewed and assessed they were meeting patient's needs. We read information from Quality Outcomes Framework (QOF), significant events, new guidance and feedback from patients generated clinical audits. 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. The practice also used the information collected for the QOF and performance against national screening programmes to monitor outcomes for patients. This practice was not an outlier for any QOF (or other national) clinical targets.

The practice showed us clinical audits that had been undertaken in the last year. These were a range of completed audits from which the practice was able to demonstrate the changes resulting since the initial audit. For example, following publication of a research article which highlighted that whilst obesity was the commonest cause of non-alcoholic fatty liver disease, it can arise secondary to underlying thyroid dysfunction. The practice audited patients with a diagnosis of non-alcoholic fatty liver disease to ensure they had undergone testing for hypothyroidism. The initial audit found 79% had been tested; the re- audit in 2015 found all patients had been

Good

Are services effective?

(for example, treatment is effective)

tested. This audit demonstrated an improvement in patient care. The practice presented a variety of audits undertaken all of which had clear actions taken which impacted on patient treatment.

The team was making use of clinical audit tools, clinical supervision and staff meetings to monitor the performance of the practice. The staff we spoke with discussed how they reflected on the outcomes being achieved and areas where this could be improved.

There was a protocol for repeat prescribing which followed national guidance. Staff regularly checked that patients who received repeat prescriptions had been reviewed by the GP if necessary. They also checked that all routine health checks were completed for long-term conditions such as diabetes. The patient record system flagged up relevant medicines alerts when the GP was prescribing medicines. We saw evidence to confirm that, after receiving an alert, the GPs had reviewed the use of the medicine in question.

The practice had a palliative care register and had regular internal as well as multidisciplinary meetings to discuss the care and support needs of patients and their families. All of the staff had attended Gold Standard Framework (GSF) training and they had a GSF board in reception so the most vulnerable patients are red flagged through the system. The practice routinely shared information with the palliative care team and OOH service.

Effective staffing

Practice staffing included medical, nursing, managerial and administrative staff. We reviewed staff training records and saw staff were up to date with attending mandatory courses such as annual basic life support. If there were gaps in training, this was highlighted and planned for individual staff. We noted a good skill mix among the GPs with interest in diabetes, GP training and contraception such as coils and implants. All GPs were up to date with their yearly continuing professional development requirements and all either have been revalidated or had a date for revalidation. (Every GP is appraised annually, and undertakes a fuller assessment called revalidation every five years. Only when revalidation has been confirmed by the General Medical Council can the GP continue to practise and remain on the performers list with NHS England).

The practice nurses had defined duties and were able to demonstrate that they were trained to fulfil these duties. For example, administration of vaccines, cervical cytology and family planning. Those with extended roles such as seeing patients with long-term conditions such as asthma, COPD, diabetes and coronary heart disease were also able to demonstrate that they had appropriate training to fulfil these roles. We were told by all levels of staff that they were provided with the time and the opportunity to undertake training and personal development. Staff told us annual appraisals identified learning needs from this action plans were developed and documented.

Working with colleagues and other services

The practice worked with other service providers to meet patient's needs and to work in a coordinated way to manage the needs of patients with complex needs. The practice had attached staff such as health visitors, midwife's and the community nursing team. It received blood test results, X ray results, and letters from the local hospital including discharge summaries, out-of-hours GP services and the 111 service both electronically and by post. The practice had a policy outlining the responsibilities of all relevant staff in passing on, reading and acting on any issues arising from communications with other care providers on the day they were received. The GP who saw these documents and results was responsible for the action required so patient care would be provided in a timely way. The information was then passed to the usual GP for review and any other consideration needed. All staff we spoke with understood their roles and felt the system in place worked well.

There was multidisciplinary team working for patients identified as 'at risk' through age, social circumstances and multiple healthcare needs. Regular meetings with other professionals such as the community nursing teams, health visitors, palliative care team took place. Staff felt this system worked as there was a team approach to supporting their patients. They also liaised with the local community nursing team when older or disabled patients were discharged from hospitals at short notice to make sure that a care plan was in place for the patient and the relevant medication was ordered and delivered to the patient.

Information sharing

Good

Are services effective?

(for example, treatment is effective)

The practice used several electronic systems to communicate with other providers. For example, there was a shared system with the local GP out-of-hours provider to enable patient data to be shared in a secure and timely manner. The practice also used the electronic booking systems for secondary appointments, patient to patient electronic transfer of medical records and summary care records. The practice had systems to provide staff with the information they needed. Staff used an electronic patient record to coordinate, document and manage patients' care. All staff were fully trained on the system. This software enabled scanned paper communications, such as those from hospital, to be saved in the system for future reference. The practice also had an internal system to shared documents and records relating to the running of the service, clinical protocols, policies and procedures were all available to staff electronically.

For emergency patients, there was a policy of providing a printed copy of a summary record for the patient to take with them to A&E. The practice had 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).

Information was shared with other health care professionals in an appropriate way, for example, we heard from community teams that they were able to link into the practice patient electronic records to add information. The community teams also attended meetings at the practice to share information.

Consent to care and treatment

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

All clinical staff demonstrated a clear understanding of Gillick competencies. (These are used to help assess whether a child had the maturity to make their own decisions and to understand the implications of those decisions).

There was a practice policy for documenting consent for specific interventions. For example, for all minor surgical procedures, a patient's verbal consent was documented in the electronic patient notes with a record of the discussion of relevant risks, benefits and complications of the procedure.

We spoke with patients who confirmed that consent was asked routinely by staff when carrying out an examination or treatment. They also told us that staff always waited for consent or agreement to be given before carrying out a task or making personal contact. They also confirmed that if patient's declined this was listened to and respected.

Health promotion and prevention

The practice had met with the local authority and the clinical commissioning group in respect of public health and health promotion, to identify and share information about the needs of the practice population. The practice website had information about healthy lifestyles as well as practical guidance about self-treatment for minor illness. We noted the culture of the practice was to use their contact with patients to help maintain or improve mental, physical health and well-being. This was reflected by the information available to patients in the waiting room which had dedicated notice boards for specific topics. We heard about the joint project the practice had with the local community schools which identified the best way to promote understanding about the role of the GP practice and communicate information to younger patients.

The practice provided information and signposted patients to services which help maintain or improve their mental, physical health and wellbeing. The practice had numerous ways of identifying patients who needed additional support, and it was pro-active in offering additional help.

Good

Are services effective?

(for example, treatment is effective)

There were patient registers for patients assessed at risk such as learning difficulties, dementia and mental health. The practice manager told us the registers for patients were kept under review. For example, the practice kept a register of all patients with a serious mental illness with an agreed care plan. We found 93% of these patients had received an annual review, whilst 77% with a diagnosis of dementia had also attended for an annual review. These exceed expected QOF targets and were higher than other practices in the CCG area. Similar mechanisms of identifying "at risk" groups were used for patients such as those receiving end of life care, and these patients were offered service support according to their needs. We saw evidence that these lists were reviewed every month.

The practice participated in the national screening programs such as those for cervical cancer, and bowel cancer. There was a process to follow up patients if they had not attended. The practice offered a full range of immunisations for children, travel vaccines and flu vaccines. We were told that flu vaccination clinics were held at weekends to encourage children and families to receive the vaccination. Practice nurses also held clinics in care homes and visited patients at home as part of the flu vaccination program. The practice's performance for cervical smear uptake was good at 82% of eligible patients, which was better than others in the CCG area. There was a policy to offer letter and telephone reminders for patients who did not attend for cervical smears; the practice audited patients who do not attend.

The practice offered a full range of immunisations for children, h**uman papilloma virus** (HPV), travel vaccines and flu vaccinations in line with current national guidance. The most recent results indicated for children at 24 months:

- Dtap/IPV/Hib a (5-in-1 vaccine that is given to babies to develop immunity to five potentially deadly diseases: diphtheria, tetanus, whooping cough (pertussis), polio and Haemophilus influenza) vaccination achievement was 100.0% CCG average 97.0%
- MMR (Mumps Measles Rubella) vaccination achievement was 100.0% CCG average 94.4%
- Infant Meningitis C vaccination achievement was 100.0% CCG average 94.4%
- Meningitis C Booster vaccination achievement was 100.0%CCG average 94.4%

Advice and information was readily available in the practice about a wide range of topics from health promotion to support and advice. Information was also available on the practice website or patients were directed to links to other providers for specific advice. We saw patients could be referred to services such as weight management and physical activity.

Good

Are services caring?

Our findings

Respect, dignity, compassion and empathy

We reviewed the most recent data available for the practice on patient satisfaction. This included information from the latest national GP patient survey information was a survey of 257 patients with a return rate of 51%. The evidence from all this showed patients were satisfied with how they were treated and that this was with compassion, dignity and respect. For example, data from the national GP patient survey showed 94.9% of patients felt that their overall experience was good or very good in comparison to the CCG average of 88.6% and England average of 67.9%.

Patients completed CQC comment cards to tell us what they thought about the practice. We received 11 completed cards which were positive about the service experienced. Patients said they felt the practice offered an excellent service and staff were efficient, helpful and caring. They said staff treated them with dignity and respect. We also spoke with the patient participation group on the day of our inspection. All told us they were satisfied with the care provided by the practice. Patients stated they felt GPs took an interest in them as a person and overall impression was one of wanting to help patients. We were given many examples of the GPs taking additional time to ensure patients received the care they needed such as making contact with patients outside of normal working hours and contacting secondary medical services to ensure referrals were received. All the patients we spoke with said they would recommend the practice.

Patients told us staff go the extra mile and the care they received exceeded their expectations. For example, we heard that sorting out patient problems was a priority and reception staff would liaise with other services to enable patients to access services such as volunteer transport. Both patients and staff expressed the service had a holistic approach and a culture which put patients first.

Patients also spoke highly of the relationships between them and the staff at the practice. We heard staff recognised and respected patients' needs taking personal and social needs into account. For example, the practice worked in partnership with numerous organisations such as Compass Carers who are funded to provide carers support. We were told by the practice manager that they were flexible when registering patients whose circumstances may make them vulnerable such as the homeless. We saw that the practice worked proactively with patients with learning disabilities and had invited representatives to use part of the waiting room as an area where accessible information was available and also provided a quiet and familiar area for patient to wait for appointments. The practice also had a private room off the waiting room if patients needed privacy or a completely private area in which to wait for their appointment.

The reception supervisor told us about the relationship with patients and how they shared their knowledge and observations with the clinical team. For example, they had noted changed behaviour in one patient which was relayed to the GP, who arranged for the patient to be seen and treated.

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

We saw that staff were careful to follow the practice's confidentiality policy when discussing patients' treatments so that confidential information was kept private. The practice switchboard was located away from the reception desk to keep patient information private. The reception desk was also separated from the waiting room. This prevented patients overhearing potentially private conversations between patients and reception staff. We saw this system in operation during our inspection and noted that it enabled confidentiality to be maintained.

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

Care planning and involvement in decisions about care and treatment

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

Good

Are services caring?

- 99% of respondents had confidence and trust in the last GP they saw or spoke to with the CCG average at 94.8% and England average 92.2%.
- 92% would recommend the practice to other patients with the CCG average at 82.7% and England average 78%.

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

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

We found that more than the required 2% of the patient population identified as vulnerable had their own care plan. We were told that the GPs acted as the care coordinator for a number of patients, all the plans had been reviewed. We found this provided a continuity of care and support for the patient because GPs could recall their patients and the particular circumstances, for example, if there was any local support or care. The care plans included information about end of life planning and choices made by the patient. Similar evidence was seen in regard of patients diagnosed with long-term conditions. Older patients, over 75, had their own named GP. Children and young people attending appointments told us they were treated in an age-appropriate way, and how GPs and nurses involved them in the consultation and acted on their preferences.

Patient/carer support to cope emotionally with care and treatment

The survey information we reviewed showed patients were positive about the emotional support provided by the practice and rated it well in this area. For example, 88.5% said the last GP they saw or spoke with was good at treating them with care and concern above the CCG average of 86.1% and England average of 82.7%. The views of the patients we spoke with on the day of our inspection and the comment cards we received were consistent with this patient response. For example, these highlighted that staff responded compassionately towards carers and family members when they needed help and provided support when required.

Notices in the patient waiting room, on the TV screen and patient website told patients how to access a number of support groups and organisations. The practice's computer system alerted GPs if a patient was also a carer. We were shown the written information available for carers to ensure they understood the various avenues of support available to them. We were told how access to appointments was flexible to patients who were carers. We were told how the GPs and health care staff were flexible in providing home visits to reduce the difficulties carers of patients had attending the practice. An example of the being home visits to patients and their carer for influenza immunisations.

One of the staff acted as a carer's champion for the practice and because the practice's computer system alerted GPs if a patient was also a carer all carers were identified and sent relevant information. This may include benefits advice, carer breaks/holiday, emergency card scheme, introduction to voluntary agencies and social services, as well as general support. The practice was part of the North Sedgemoor Federation which funded a new Somerset Village Agent project; this was initiated in 2014 and was funded until 2016. The project used paid, part time, highly trained individuals living in the parish 'clusters' they supported. They helped to bridge the gap between socially isolated, excluded, vulnerable and lonely individuals, and the statutory and/or voluntary organisations which offered specific solutions to identified needs.

The practice had set up an independent charitable 'Medical Equipment Fund' which was used in a variety of ways to support patients registered at the practice. The trustees of the fund were not employees of the practice which maintained their independence. The practice staff could request equipment for the practice such as 24 hour BP monitor.

We found one GP had been nominated as an "NHS hero" which is a new scheme to recognise the work that individuals and teams do every day in the NHS. They are the only GP in Somerset to have received this award and were nominated by an ex-patient.

Good

Are services caring?

The practice had worked with local schools to inform children and young people about the practice and what happens when they visit a GP. A senior GP partner gave a yearly presentation to children at Fairlands Middle School, and we saw in the waiting room the results of a drawing competition for younger patients to further their understanding of what happened at the practice.

Staff told us that if families had suffered bereavement, their usual GP contacted them. Bereaved patients usually are visited at home and are then followed up by a patient consultation at a flexible time and location to meet the family's needs and/or by giving them advice on how to find a support service.

The information from patients showed patients were positive about the emotional support provided by the practice staff. Some of the GPs also continued to make themselves available in the out of hours periods for palliative care patients so they had continuity of care. For example, we were told by one patient they were able to speak to the GPs on the telephone to ask questions and gain reassurance. The practice had also been proactive in identification of social isolation amongst patients and had worked to ensure there was access to facilities such as a volunteer driver service.

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 Clinical Commissioning Group (CCG) told us that the practice engaged regularly with them and other practices to discuss local needs and service improvements that needed to be prioritised.

Patients and staff told us that all patients who requested urgent attention were always seen on the day of their request this included patients requiring home visits. There was no triage of patient requests for appointments however the reception team had clear guidance on how to deal with emergencies such as sick children or patients with particular symptoms such as chest pain. Patients could also speak to the duty GP by telephone if they were anxious. The practice had provided a responsive service by holding clinics, such as the diabetes clinic, on a regular day each week for patients who found it difficult to attend variable appointment times.

There was a computerised system for obtaining repeat prescriptions and patients used both the electronic request service, posted or placed their request in a drop box in reception, patients told us these systems worked well for them. The practice used electronic prescribing and had arranged with local pharmacies that urgent prescriptions were delivered to older or infirm patients on the same day.

The practice had a Patient Participation Group (PPG) and patients were able to provide feedback about the quality of services at the practice through the PPG. The PPG carried out patient surveys and there was evidence that information from these was used to develop services provided by the practice. Representatives from the PPG said the practice listened to the comments patients made about the service. For example, instigating information boards which promoted the objectives of the PPG.

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

Tackling inequity and promoting equality

The practice had access to online and telephone translation services. The practice provided equality and diversity training for all staff. We also saw that the information on the website could be translated.

The premises and services had been designed to meet the needs of patients with disabilities. We saw wheelchair access at the entrance to the practice, an accessible toilet and sufficient space in the waiting room to accommodate patients with wheelchairs and pushchairs which allowed for easy access to the treatment and consultation rooms. The services for patients were on the ground floor; there was no lift access to the first floor. We noted that the practice was a dementia friendly environment with good lighting and clear signage to assist patients around the premises.

The practice had recognised the needs of different groups in the planning of its services. The practice provided home visits to patients who were unable to attend the practice and to those living in residential or nursing home.

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

Access to the service

The practice was open on Monday to Friday 8.30am - 6pm for on the day urgent and pre-booked routine GP and nurse appointments. Patients had access to 36 urgent and 71 pre-bookable appointments during these core hours. There was a duty doctor available for emergencies only from 8am - 6.30pm. The practice does not provide any extended hours as patient demand was managed within the core hours. Each week the receptionists at the practice telephone older patients who had pre-booked appointments to remind them of the date and time of their appointment.

The practice does not provide out of hour's services to its patients, this was provided by Somerset Doctors Urgent Care with effect from 1/7/15 and information on the out-of-hours service was provided to patients. Appointments were available outside of school hours for children and young people. Comprehensive information was available to patients about appointments on the

Good

Are services responsive to people's needs?

(for example, to feedback?)

practice website. This included how to arrange urgent appointments and home visits. There were also arrangements to ensure patients received urgent medical assistance when the practice was closed.

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

Longer appointments were also available for patients who requested them, for example, those who may have more than one medical condition. This also included appointments with a named GP or nurse. The patient record system had an alert to highlight patients who required longer appointments. Home visits were made to a local care homes on a regular basis by named GPs and on request.

Listening and learning from concerns and complaints

The practice had a system in place for handling complaints and concerns. Its complaints policy and procedures were in line with recognised guidance and contractual obligations for GPs in England. There was a designated responsible person who handled all complaints in the practice.

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

We looked at the 10 complaints received in the last 12 months and found these were satisfactorily handled and dealt with in a timely way. An acknowledgement had been sent out, the issues investigated and a response sent to the complainant. The complaints ranged from a variety of issues, such as patient expectation for treatment or referral to other healthcare providers. There was a method to identify common areas of complaints. Each complaint or comment was also reviewed. Where potential serious concerns had been identified these were elevated as a significant event and then reviewed in more depth by the management team. We saw that from all complaints the practice had looked at how it could improve and avoid patients raising similar complaints in the future.

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. We heard from all the staff we spoke with that there was a 'patient first' ethos within the practice. The practice did not run personal lists and allowed the patient to have a choice of doctor; every patient had a named GP who took responsibility for that patient in terms of medication reviews, QOF reviews and follow up of hospital letters. This ensured the named GP retained responsibility and was informed about their patients. Staff told us that they treated patients with courtesy, dignity and respect at all times. The practice also participated and engaged with colleagues as part of the North Sedgemoor federation of general practices in Somerset.

Governance arrangements

The practice employed a practice manager to enable the business and administration of the service. Their responsibilities included the development and implementation of practice policies and procedures. The practice manager provided us with a number of policies, for example the recruitment policy and induction programmes which were in place to support staff. We were shown the online staff information that was available to all staff. Those we spoke with knew where to find these policies if required.

GPs and nursing staff were provided with clinical protocols and pathways to follow for some of the aspects of their work. For example, the handling of vaccines and medicines or ensuring a consistent approach was made for patient referrals. Information on the practice website also informed patients about policies such as confidentiality and how patients could access their own records. The practice also had a policy to follow for patients who made freedom of information requests.

We spoke with nine members of staff and they were all clear about their roles and responsibilities. They told us they felt valued, well supported and knew who to go to in the practice with any concerns

The practice used the Quality and Outcomes Framework (QOF) to measure its performance. The QOF data for this practice was equitable with national standards and was above average for the local Clinical Commissioning Group (CCG) and England average in a number of clinical indicators. The practice periodically looked at these alongside other indicators such as survey results, other forms of patient feedback and diagnosis of new cancers to provide an in depth review of service provision.

The practice had an ongoing programme of clinical audit which it used to monitor quality and systems to identify where action should be taken. For example the practice ran a six monthly

rolling audit to ensure the housebound patients with chronic kidney disease were receiving the

same monitoring as their more ambulant peers. If it was identified that a relevant biochemical test was outstanding then testing was arranged through the community nurses.

The practice held weekly partners meetings to discuss quality audits, serious and significant events, complaints, patient feedback, performance data and other information relating to the quality of the service. This ensured any risks to the delivery of care were identified and mitigated before they became issues. We found risk assessments had been carried out where risks were identified and action plans had been produced and implemented, for example, within the business continuity plan.

We discussed how the practice monitored 'at risk' patients to meet the requirements of the enhanced services. For example, the avoiding unplanned admissions enhanced service. We found the practice had systems in place for monitoring quality, for example, audits, procedures, reviews, monitoring mechanisms, questionnaires and meetings. These individual aspects of governance provided evidence of how the practice functioned and the level of service quality delivered to patients.

Leadership, openness and transparency

There was a clear leadership structure with named members of staff in lead roles. The practice provided us with a list of the areas that each partner GP in the practice led on. We saw that buddy arrangements between doctors were clearly documented and staff told us this worked very well in practice and provided a safety network for patients. For example, when a GP was absent, a buddy would check correspondence and the on call doctor checked results, so that nothing urgent was missed, and nothing was filed so it can reviewed by the GP who requested the test.

Are services well-led?

Good

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

Staff were able to tell us what was expected of them in their role and how they kept up to date. Staff told us there was an open culture in the practice and they could report any incidents or concerns about the practice. Staff told us they felt supported by the practice manager and the clinical staff and they worked well together as a team. We heard from staff at all levels that team meetings were held regularly and that the practice held a yearly meeting where representatives from all staff groups attended.

The practice had invited a number of key stakeholders to speak with us during the inspection. All spoke highly of the practice and how well the practice worked jointly with their organisation. The practice invited us to sit in on the planned patient participation group meeting where the members expressed their views and involvement with the practice. This confirmed an open and transparent approach by the practice and demonstrated their commitment to patient involvement.

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

Seeking and acting on feedback from patients, public and staff

The practice demonstrated a strong commitment to seeking and listening to patient views. They welcomed rigorous and constructive challenge from patients who used the service, the public and stakeholders. Throughout the inspection they demonstrated how patient views had influenced improvements in patient care and service. They showed us a range of evidence, such as patient feedback, compliments and complaints they had used to focus improvements on the needs and wishes of patients. This included celebrating what had gone well as well as identifying areas for improvement. For example, the practice had gathered feedback from patients through patient surveys, complaints received and the recently implemented friends and family questionnaire.

The patient participation group (PPG) included representatives from various population groups; patients of working age and recently retired and older patients groups. The PPG met quarterly and had a planned timetable for the year of issues and events which they were involved in. We saw evidence from meetings and from discussion with the chair and deputy chair of the PPG of the changes they had been able to influence within the practice. For example,

- information was now available in the practice about the PPG and its' projects on two notice boards which the PPG maintained
- leaflets about the PPG were going to be placed in new patients registration packs, there was a practice newsletter in the process of being produced
- the PPG had helped out at the flu clinics
- PPG representatives attended local Connect Cheddar meetings which influence local community services such as volunteer transport for patients to get to the practice.

The practice had gathered feedback from staff through team meetings, appraisals and discussions. Staff told us they would not hesitate to give feedback and discuss any concerns or issues with colleagues and management. Staff told us they felt involved and engaged in the practice to improve outcomes for both staff and patients.

The practice had a whistleblowing policy which was available to all staff in the staff handbook and electronically on any computer within the practice.

Management lead through learning and improvement

The practice was proactive in planning for future needs; GPs and nurses were being provided the opportunities and access to additional training to develop new services and enhance their skills. GPs and nurses routinely updated their knowledge and skills, for example by attending learning events provided by the Somerset Clinical Commissioning Group (CCG), completing online learning courses and reading journal articles. Staff told us that the practice supported them to maintain their clinical professional development through training and mentoring. In the staff files we looked at we saw that regular appraisals took place which included a personal development plan.

Learning also came from significant events, clinical audits and complaints. We heard from the GPs that sharing information and cascading learning through the team was an established process and one which kept the staff informed and up to date. The practice had completed reviews of significant events, complaints and other

Are services well-led?

Good

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

incidents. Significant events were a standing item on the practice meeting agenda and were attended by the GPs and the practice manager. There was evidence the practice had learned from these events and that the findings were shared. For example, we were told about a scenario whereby a patient had collapsed in the car park and a practice GP provided emergency treatment. This was recorded as a significant event and reviewed to identify any learning. As a result the nurses developed a '1, 2, 3 system' for the emergency kit held by the practice which ensured staff knew what the GP needed, and where to find it.

The practice was a GP training practice with one partner who took the lead for GP training.The ethos of the practice was that GPs in training brought new ideas and ways of working to the practice, and were able to challenge established practice.

The practice participated in joint working for local service developments such as the Village Agent.